PARTICIPATING PHYSICIAN PROGRAM UNDER MEDICARE PART B

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

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CONTENTS

Page

Press release of Thursday, April 30, 1987, announcing the hearing 2

WITNESSES

U.S. Department of Health and Human Services, Health Care Financing Administration, William L. Roper, M.D., Administrator 3

American Medical Association, John H. Dawson, M.D., and Bruce Blehart 78
Blue Cross and Blue Shield Association, William R. Newsom and Frank E. Broadus, Jr., Blue Cross and Blue Shield of Kentucky 58
Health Economics Research, Inc., Jerry Cromwell 52
Massachusetts Senior Action Council, Inc., Manny Weiner 23
National Council of Senior Citizens, Edward Carrig and Ken Anderson 28
Villers Advocacy Associates, Ronald F. Pollack 41

SUBMISSIONS FOR THE RECORD

American Association of Retired Persons, statement and attachment 89
American Society of Internal Medicine, statement 100
MediVision, Inc., Eric Kriss, statement 106
National Committee to Preserve Social Security and Medicare, Hon. James Roosevelt, statement 116

PARTICIPATING PHYSICIAN PROGRAM UNDER MEDICARE PART B

THURSDAY, MAY 7, 1987

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:15 a.m., in room B-318, Rayburn House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

HON. FORTNEY H. (PETE) STARK (D. CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON THE PARTICIPATING PHYSICIAN PROGRAM UNDER MEDICARE PART B TO BE HELD ON THURSDAY, MAY 7, 1987

The Honorable Fortney H. (Pete) Stark (D. Calif.), Chairman of the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives announced today that the Subcommittee will hold a hearing on the participating physician program under Medicare Part B. The hearing will be held on Thursday, May 7, 1987, beginning at 10:00 a.m., in room B-318 Rayburn House Office Building.

In announcing the hearing, Chairman Stark said, "Extra charges on unassigned claims are a heavy financial burden for the elderly. The participating physician program gives the elderly the freedom to choose a physician who agrees in advance not to charge more than the Medicare-approved fee. For this reason, strengthening the program is a high priority. The purpose of the May 7 hearing is to explore options to improve the participating physician program and to review alternative approaches, including limits on extra billing and State mandatory assignment laws."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

Under current law, physicians (and other Part B providers) have the option of accepting or refusing assignment. If assignment is accepted, the physician submits a claim to Medicare directly and bills the patient for the standard 20 percent coinsurance payment. No extra charges are permitted. However, if assignment is refused, the physician bills the patient and may charge more than the Medicare-approved fee.

During 1987, extra charges on Part B services will total more than $3 billion and 700,000 elderly will incur extra charges in excess of $1,000.

The ability of physicians to charge extra makes it difficult to control rapidly growing program outlays. Congress is unwilling to enact savings measures if physicians are able to shift the impact to the elderly by increasing extra charges on unassigned claims.

To deal with these concerns, Congress enacted the participating physician program in 1984. A participating physician agrees to accept assignment on all Medicare claims during a 12-month period. To encourage participation, participating physicians receive a four percent payment bonus. There also are important marketing advantages. A directory of participating physicians will be sent free of charge to

Medicare beneficiaries upon request. In addition, carriers are required to conduct outreach programs to familiarize beneficiaries with the participating physician program and assist them in selecting a participating physician.

Congress also enacted a freeze on the charges of nonparticipating physicians in 1984. Last year, Congress replaced the freeze with a four-year policy limiting the rate of increase of nonparticipating physicians' charges.

At the State level, elderly groups are urging enactment of laws requiring physicians to accept assignment. The first law of this type was enacted by Massachusetts in 1985. The Massachusetts law has successfully withstood court challenges. Similar legislation is pending in a number of other States.

WRITTEN STATEMENT IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, May 15, 1987, to Joseph K. Dowley, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

Chairman STARK. The Chair apologizes to the witness and Members for starting late. This morning the Subcommittee on Health will begin a hearing on the participating physician program.

Today, after 20 years, Medicare payments cover less than half the total health costs of the elderly, and Medicare pays about two-thirds of the amount owed on physician's bills. Extra charges on unassigned claims are a major part of this financial problem.

During 1984 physician charges on unassigned claims averaged 25 percent more than the Medicare approved charge. Extra charges on services covered by Medicare will total more than $3 billion this year.

That burden falls most heavily on those who become severely ill and require extensive care. Seven hundred thousand enrollees will incur more than $1,000 of extra charges this year.

Extra billing also has budgetary implications. Congress has been and continues to be willing to adopt policies that would increase extra charges on unsigned claims. The House budget resolution directs that savings must not be achieved through policies that could increase out-of-pocket costs for the elderly.

One approach is to mandate assignment. At a State level, mandatory assignment is gathering support. Massachusetts has enacted a State mandatory assignment law and similar legislation is pending in more than 17 States.

Thus far, Congress has been reluctant to embrace mandatory assignment. However, it hangs out there as a punitive alternative and there is pressure mounting for it. In the meantime, we have enacted the participating physician program as an alternative. Strengthening that program is the Chair's highest priority for the part B program in Medicare.

The participating physician program gives the elderly the freedom to choose a physician who agrees in advance to accept assignment on all services. In turn, the Government offers the participating physician some advantages. Our efforts to increase participation are beginning to work. Forty-four percent of all services are now being provided by participating physicians. Thirty one percent of physicians have agreed to participate, up from 28 percent last year.

These results are particularly impressive in view of the widespread confusion among physicians during the December enrollment period. This confusion was the result of the American Medical Association's attempt to delay the program by means of legislative tactics and some dubious and baseless litigation.

More needs to be done to make participation more attractive for physicians. Options include an increase in the payment bonus, one-stop billing, faster payment, and increased efforts to publicize the program.

I hope that those representing organized medicine will begin to work with us rather than against us in this effort. The participation program is a voluntary alternative to mandatory assignment and I hope it can be presented to be in everyone's interest, which will then make the program succeed.

We are honored to have as our first witness Dr. William Roper, the Administrator of the Health Care Financing Administration.

Welcome back to the committee, Doctor. Your entire prepared statement will appear in the record, as will without objection, the entire prepared statements of all witnesses, and you may expand on it, summarize it for us, or present your testimony in any manner you are comfortable.

STATEMENT OF WILLIAM L. ROPER, M.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Dr. ROPER. Thank you Mr. Chairman and members of the committee.

I am delighted to be with you this morning to discuss the participating physician program, or the "Pardoc" program, as we call it.

The administration strongly supports the participating physician program. It is voluntary, it promotes competition, and it encourages beneficiary choice. We believe it has advantages both for the Medicare beneficiary and for the physician.

Medicare offers physicians the option to accept assignment of Medicare benefits on a claim-by-claim basis. If assignment is not accepted, the physician may charge the beneficiary an amount over the Medicare approved payment. This provides maximum flexibility for the physician, but frequently Medicare beneficiaries may not know whether or not assignment is accepted before service is rendered.

Under the Pardoc program created by the Deficit Reduction Act of 1984, physicians and suppliers may make a voluntary choice each year to accept assignment on all Medicare claims for the following year. Incentives are provided for suppliers and physicians to participate.

Some of these incentives include a 4 percent higher prevailing charge for participating physicians and informational and referral activities such as directories and toll-free telephone lines.

We have just compiled data on the response for the fourth participation period which extends from January to December of this year. At this time, 30.6 percent of physicians and 18.6 percent of suppliers have signed participation agreements. This compares to lower rates in the past year.

We are setting all-time records in the Pardoc program. Perhaps more significant has been the general upward trend in the percent of Medicare payments to participating physicians since the beginning of this program.

For the first quarter of 1987, services provided by participating physicians represented 44 percent of spending for physician services. That is compared to 35 percent during the first quarter of 1985. We believe the higher physician participation rates from this most recent enrollment period indicate that our efforts to increase participation have been successful.

In addition to the improvement in participation rates, there has been a significant improvement in assignment rates. In 1984 the overall assignment level was 58 percent. This year it is 71 percent.

Enacting legislation for the participating physician program did not allow us much time to notify physicians of their options, or for physicians to make an informed decision.

Chairman STARK. Excuse me, sir. Seventy-one percent assignment. Does that mean that 71 percent of the bills were——

Dr. ROPER. Or dollars.

Chairman STARK [continuing]. Or dollars paid out were on assignment. There was no extra billing?

Dr. ROPER. Seventy-one percent of claims.

Chairman STARK. Claims. Okay.

Dr. ROPER. Excuse me, I am corrected. It is dollars. Seventy-one percent of the dollars paid to physicians and suppliers were paid on assignment.

Chairman STARK. That does not have any bearing to how many physicians or how many people. You cannot relate that to the 28 to 33 percent of physicians participating?

Dr. ROPER. Right.

Chairman STARK. Okay.

Dr. ROPER. The figure is 31 percent of physicians are participating physicians and accept assignment on all of their claims. In addition, some physicians do it on a case-by-case basis. The total amount is therefore 70-plus percent.

Chairman STARK. My next question then is, what portion of the 31 percent who participate, are responsible for the 71 percent assignment? Do you see what I am saying?

Dr. ROPER. Sure.

Chairman STARK. One would presume that a large number of those claims are from participating physicians. You can get that later.

Dr. ROPER. I have got it for you.

Chairman STARK. Okay.

Dr. ROPER. Thirty-one percent of physicians make up 44 percent of charges under the program, so nearly one-half of the program is comprised of Pardocs doing their work.

Chairman STARK. So 27 percent of the assignment claims were from non-"Pars"?

Dr. ROPER. Yes.

As you said, Mr. Chairman, last year a lawsuit temporarily delayed implementation of new incentives from OBRA-86. The court ruled on January 20 of this year that the Department could proceed with the implementation that establishes the prevailing

charge for nonparticipating physicians at 96 percent of the level for participating physicians.

Let me bring you up to date about our implementation, and about various activities to increase participation levels. We have revised the explanation of Medicare benefits notices sent to all Medicare beneficiaries who are on unassigned claims. We have new Pardoc directories, and you should have the one for your States in front of you.

On April 3 we mailed a notice to all 31 million beneficiaries as to how they could go about getting a copy of these directories.

Our research has shown that there may be factors that can predict which physicians will choose to become participating physicians. These factors include specialty, geographic location, size of Medicare caseload, and Medicare payment levels.

We are continuing research to help us target our future enrollment efforts. We have in place a program to give carriers an incentive to sign up more physicians in the participation program.

In conclusion, let me say we strongly support this program. It is voluntary for the physicians and assures beneficiaries the widest possible access to physicians. It promotes competition and beneficiary choice, and it permits beneficiaries to know whether there will be balance billing. We are working hard to improve and strengthen the program.

I am anxious to answer your questions.

[The statement of Dr. Roper follows:]

STATEMENT OF

WILLIAM L. ROPER, M.D.

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I AM PLEASED TO BE HERE TODAY TO DISCUSS THE MEDICARE PARTICIPATING PHYSICIAN PROGRAM.

THE ADMINISTRATION STRONGLY SUPPORTS THE PARTICIPATING PHYSICIAN PROGRAM. THIS PROGRAM IS VOLUNTARY; IT PROMOTES COMPETITION; AND IT ENCOURAGES BENEFICIARY CHOICE. IT HAS ADVANTAGES FOR BOTH THE MEDICARE BENEFICIARY AND THE PHYSICIAN.

BACKGROUND

PRIOR TO THE PARTICIPATING PHYSICIAN AND SUPPLIER PROGRAM, PHYSICIANS COULD ACCEPT ASSIGNMENT OF MEDICARE BENEFITS ON A CLAIM-BY-CLAIM BASIS. WHEN ASSIGNMENT IS ACCEPTED, THE PHYSICIAN SUBMITS THE CLAIM DIRECTLY TO MEDICARE AND AGREES TO ACCEPT THE MEDICARE-APPROVED CHARGE AS PAYMENT-IN-FULL, EXCEPT FOR APPLICABLE COST-SHARING. WHEN ASSIGNMENT IS NOT ACCEPTED, THE PHYSICIAN BILLS THE MEDICARE BENEFICIARY WHO COLLECTS THE APPLICABLE REIMBURSEMENT FROM MEDICARE AND IS FINANCIALLY RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE MEDICARE APPROVED-CHARGE AND THE PHYSICIAN'S ACTUAL CHARGE. WHILE THIS SYSTEM PROVIDED FOR THE MAXIMUM FLEXIBILITY FOR PHYSICIANS, FREQUENTLY, THE MEDICARE BENEFICIARY DID NOT KNOW WHETHER OR NOT ASSIGNMENT WOULD BE ACCEPTED BEFORE THE SERVICE WAS RENDERED.

THE DEFICIT REDUCTION ACT (DEFRA) CREATED THE PARTICIPATING PHYSICIAN PROGRAM EFFECTIVE OCTOBER 1984. UNDER THIS PROGRAM, PHYSICIANS AND SUPPLIERS MAY MAKE A VOLUNTARY CHOICE EACH YEAR TO ACCEPT ASSIGNMENT ON ALL MEDICARE CLAIMS FOR THE FOLLOWING YEAR. A CHOICE NOT TO PARTICIPATE MEANS THAT THE PHYSICIAN OR SUPPLIER MAY CONTINUE TO DECIDE ON A CLAIM-BY-CLAIM BASIS WHETHER TO ACCEPT ASSIGNMENT OR BILL THE BENEFICIARY FOR CHARGES THAT EXCEED THE MEDICARE APPROVED AMOUNT.

DEFRA, AND LATER THE CONSOLIDATED OMNIBUS RECONCILIATION ACT (COBRA) AND THE OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (OBRA-86), PROVIDED INCENTIVES FOR PHYSICIANS AND SUPPLIERS TO PARTICIPATE. SOME OF THESE INCENTIVES INCLUDE A 4 PERCENT HIGHER PREVAILING CHARGE LEVEL FOR PARTICIPATING PHYSICIANS AND INFORMATIONAL AND REFERRAL ACTIVITIES, SUCH AS DIRECTORIES AND TOLL-FREE TELEPHONES, TO FACILITATE BENEFICIARY USE OF PARTICIPATING PHYSICIANS.

RESULTS

SINCE THE PARTICIPATING PHYSICIAN PROGRAM WAS ENACTED, THERE HAVE BEEN FOUR PERIODS DURING WHICH PHYSICIANS COULD ELECT TO PARTICIPATE IN MEDICARE. WE HAVE JUST COMPILED DATA ON THE RESPONSE FOR THE MOST RECENT PARTICIPATION PERIOD WHICH EXTENDS FROM JANUARY TO DECEMBER 1987. FOR THE CURRENT YEAR, 30.6 PERCENT OF PHYSICIANS AND 18.6 PERCENT OF SUPPLIERS HAVE SIGNED AN AGREEMENT TO PARTICIPATE IN MEDICARE. THIS COMPARES TO PARTICIPATION RATES OF 28.3 PERCENT FOR PHYSICIANS AND 19 PERCENT FOR SUPPLIERS DURING THE THIRD PARTICIPATION PERIOD (MAY TO DECEMBER 1986). THIS YEAR, PARTICIPATION RATES INCREASED IN 37 STATES AND THE DISTRICT OF COLUMBIA.

ANOTHER WAY TO MEASURE IMPACT IS TO CONSIDER THE RELATIVE SHARE OF MEDICARE PHYSICIAN EXPENDITURES THAT ARE PAID TO PARTCIPATING PHYSICIANS. THERE HAS BEEN A GENERAL UPWARD TREND IN THE PERCENT OF MEDICARE PAYMENTS TO PARTICIPATING PHYSICIANS SINCE THE BEGINNING OF THE PARTICIPATING PHYSICIAN PROGRAM. DURING THE FIRST QUARTER OF 1987, SERVICES PROVIDED BY PARTICIPATING PHYSICIANS REPRESENTED 43.7 PERCENT OF SPENDING FOR PHYSICIAN SERVICES COMPARED TO 35.3 PERCENT DURING THE FIRST QUARTER OF FY 1985.

WE BELIEVE THAT THE HIGHER PHYSICIAN PARTICIPATION RATES FROM THIS MOST RECENT ENROLLMENT PERIOD INDICATE THAT OUR EFFORTS TO INCREASE PARTICIPATION HAVE BEEN SUCCESSFUL.

IN ADDITION TO THE IMPROVEMENT IN PARTICIPATION RATES, THERE HAS BEEN A SIGNIFICANT IMPROVEMENT IN ASSIGNMENT RATES SINCE THE INITIATION OF THE PARTICIPATION PROGRAM. IN 1984, PRIOR TO THE PARTICIPATION PROGRAM, ASSIGNMENT LEVELS WERE IN THE RANGE OF 58 PERCENT OF PAYMENTS. DURING THE FIRST YEAR OF THE PARTICIPATING PHYSICIAN PROGRAM, ASSIGNMENT RATES INCREASED TO 67 PERCENT. THE UPWARD TREND CONTINUED AND THIS YEAR 71 PERCENT OF EXPENDITURES ARE PAID UNDER ASSIGNMENT. WHILE OTHER FACTORS SUCH AS MANDATORY ASSIGNMENT FOR CLINICAL LABORATORY CLAIMS CONTRIBUTED TO THE INCREASE, IT SEEMS CLEAR THAT A SIGNIFICANT PORTION OF THE INCREASE CAN BE ATTRIBUTED TO THE PARTICIPATION PROGRAM.

IMPLEMENTATION OF OBRA 1986 INCENTIVES

THE PARTICIPATING PHYSICIAN PROGRAM PROVISIONS ENACTED IN DEFRA, COBRA, AND OBRA-86 REQUIRED IMPLEMENTATION IN SHORT PERIODS OF TIME. THESE LEGISLATIVE CHANGES HAVE NOT ALLOWED MUCH TIME FOR US TO NOTIFY PHYSICIANS OF THEIR OPTIONS OR FOR PHYSICIANS TO MAKE AN INFORMED DECISION. WE BELIEVE THAT THE PROCESS WOULD BE SUBSTANTIALLY IMPROVED IF THERE WAS MORE TIME FOR NOTIFICATION AND RESPONSE.

WE WERE HOPING TO AVOID DELAYS IN IMPLEMENTING THE MOST RECENT PROVISIONS. HOWEVER, A LAWSUIT TEMPORARILY ENJOINED THE DEPARTMENT FROM IMPLEMENTING POLICIES THAT TREAT NON-PARTICIPATING PHYSICIANS DIFFERENTLY FROM PARTICIPATING PHYSICIANS, PARTICULARLY WITH REGARD TO PAYMENT RATES. THE COURT RULED ON JANUARY 20, 1987 THAT THE DEPARTMENT COULD PROCEED TO IMPLEMENT THE PROVISIONS WHICH PAY PARTICIPATING PHYSICIANS FOUR PERCENT MORE THAN NONPARTICIPATING PHYSICIANS.

I WOULD LIKE TO BRING YOU UP TO DATE WITH SOME OF OUR RECENT ACTIVITIES TO INCREASE PARTICIPATION LEVELS.

WE HAVE REVISED THE "EXPLANATION OF MEDICARE BENEFITS NOTICES" THAT ARE SENT TO MEDICARE BENEFICIARIES ON UNASSIGNED CLAIMS TO INCLUDE A REMINDER OF THE PARTICIPATING PHYSICIAN AND SUPPLIER PROGRAM.

NEW PARTICIPATING PHYSICIAN DIRECTORIES WERE MADE AVAILABLE BY MARCH 23, 1987. ON APRIL 3 BENEFICIARIES RECEIVED A NOTICE WITH THEIR SOCIAL SECURITY CHECKS ADVISING THEM THAT THEY COULD RECEIVE A COPY OF THIS DIRECTORY FREE OF CHARGE UPON REQUEST FROM THEIR CARRIER. I HAVE WITH ME TODAY A COPY OF THE DIRECTORY FOR THE AREA REPRESENTED BY EACH MEMBER OF THE SUBCOMMITTEE.

WE ALSO HAVE MADE THESE DIRECTORIES AVAILABLE TO HOSPITALS AND AMENDED OUR HOSPITAL PROVIDER AGREEMENTS TO REQUIRE THAT BENEFICIARIES BE INFORMED OF THEIR OPTION TO BE SERVED BY A PARTICIPATING PHYSICIAN IF THEY REQUIRE FOLLOW-UP SERVICES AFTER DISCHARGE FROM THE HOSPITAL.

WE ARE DEVELOPING OTHER INITIATIVES FOR IMPLEMENTATION IN FY 1988 THAT WE BELIEVE WILL INCREASE PARTICIPATION RATES FURTHER. CARRIERS WILL BE REQUIRED TO ESTABLISH PROGRAMS TO RECRUIT AND RETAIN PARTICIPATING PHYSICIANS AND SUPPLIERS AND TO ASSIST BENEFICIARIES TO LOCATE PARTICIPATING PHYSICIANS. AN INCENTIVE POOL OF ONE PERCENT OF TOTAL CARRIER PAYMENTS WILL BE SET ASIDE TO REWARD CARRIERS WHO ARE SUCCESSFUL IN INCREASING THE NUMBER OF PARTICIPATING PHYSICIANS IN THEIR SERVICE AREA DURING THE NEXT PARTICIPATION PERIOD.

RESEARCH

WE ARE CONTINUING OUR RESEARCH TO UNDERSTAND BETTER THE FACTORS THAT INFLUENCE PHYSICIANS TO PARTICIPATE. THIS INFORMATION WILL ASSIST US IN TARGETING OUR INCENTIVE PROGRAMS.

OUR PAST RESEARCH HAS PROVIDED INFORMATION ON CHARACTERISTICS OF PHYSICIANS WHO CHOOSE TO PARTICIPATE. THIS RESEARCH HAS SHOWN THAT THERE MAY BE FACTORS THAT CAN PREDICT WHICH PHYSICIANS WILL CHOOSE TO BECOME PARTICIPATING PHYSICIANS. FOR EXAMPLE, IN 1984 THERE WAS A WIDE RANGE OF PARTICIPATION RATES AMONG SPECIALTIES, WITH GENERAL SURGEONS AND PATHOLOGISTS HAVING THE HIGHEST RATES AND FAMILY PRACTITIONERS AND ANESTHESIOLOGISTS HAVING THE LOWEST.

THERE WERE ALSO GEOGRAPHIC VARIATIONS. WE ALSO FOUND THAT PARTICIPATION RATES WERE HIGHEST AMONG PHYSICIANS WHO HAVE A LARGE MEDICARE PATIENT CASELOAD AND LEAST AMONG THOSE PRACTICING IN THE SOUTH AND WEST.

CURRENT RESEARCH WILL ADDRESS OTHER FACTORS THAT MAY INFLUENCE PARTICIPATION DECISIONS INCLUDING MEDICARE PAYMENT LEVELS AND LEVEL OF COMPETITION. PRELIMINARY ANALYSIS SUGGESTS THAT THE PARTICIPATING DECISION MAY BE HIGHLY SENSITIVE TO MEDICARE REIMBURSEMENT LEVELS. HIGHER COLLECTION COSTS FROM BENEFICIARIES MAY ALSO ENCOURAGE PARTICIPATION. THERE IS NO EVIDENCE THAT BOARD CERTIFIED PHYSICIANS ARE LESS LIKELY TO PARTICIPATE.

CONCLUSION

THE ADMINISTRATION STRONGLY SUPPORTS THE PARTICIPATING PHYSICIAN PROGRAM. THE PARTICIPATING PHYSICIAN PROGRAM IS VOLUNTARY TO THE PHYSICIAN AND ASSURES BENEFICIARIES THE WIDEST POSSIBLE ACCESS TO PHYSICIANS. IT PROMOTES COMPETITION AND BENEFICIARY CHOICE IN THE MARKETPLACE. AND IT PERMITS BENEFICIARIES TO KNOW IF THERE WILL BE ADDITIONAL OUT-OF-POCKET COSTS BEFORE THE SERVICES ARE PROVIDED. THAT IS WHY WE ARE WORKING HARD TO IMPROVE AND STRENGTHEN THE PARTICIPATING PHYSICIAN PROGRAM.

I WILL BE PLEASED TO ANSWER ANY QUESTIONS THAT YOU MAY HAVE.

Chairman STARK. Thank you. I am pleased to see the booklets and I think that whatever outreach we can do is important. I hope this does not sound entirely self-serving, but I think in many congressional offices a good bit of our case work for our constituents is generated by Medicare and health problems among the elderly. I would hope that, particularly in those districts with a large number of low income people, these are some of the things that the congressional offices could do.

We all send out newsletters, to the consternation of some and to the joy of a few, and most of us are actively engaged in outreach groups with senior citizens. Various Governmental agencies provide things that we can mail, whether it is the Department of Agriculture for helpful hints for the home. Some of the literature is better than others. I think that we could cooperate with your Department, Doctor, in finding ways that the Members could be involved in this outreach. There would be some natural synergism here that would be of some help.

Dr. ROPER. We would welcome that.

Chairman STARK. I would like to suggest that on an informal basis we would like to see what we could do.

Dr. ROPER. One thing we might be able to do is provide you with a suggested insert for your newsletter that describes the program and tells how to get a directory. We would be glad to do that.

[The following was subsequently received:]

IMPORTANT NEWS ABOUT MEDICARE

Medicare Has Participating Doctors and Suppliers

What does Participating mean?

- Participating doctors or suppliers "accept assignment" on all Medicare claims. This means that they accept Medicare's approved charge as full payment on all claims. As in the past, when your doctor or supplier accepts assignment, you cannot be billed for more than 20% of Medicare's approved charge (regardless of the amount of the actual bill). Medicare pays the other 80%, after you meet the yearly deductible.

How do I know if my doctor or supplier participates?

- Ask your doctor or supplier.
- Look for a Medicare participating sign in his or her office.
- Look in a Medicare Participating Physician/Supplier Directory.

Where can I get this Directory?

- You can get it free of charge from the company that handles Medicare claims in your area. Their address is listed in the back of ***Your Medicare Handbook***. You can also see this Directory at Social Security, Railroad Retirement, or Area Agency on Aging offices, and senior citizen organizations.

Suppose my doctor or supplier doesn't participate?

- You still will have Medicare coverage.
- You still can use any doctor or supplier you wish.
- Medicare still pays 80% of the approved charge after you meet the yearly deductible. But you can be billed for more than 20% of Medicare's approved charge (unless your doctor or supplier agrees to accept assignment on your claim).

Where can I get more information?

Write or call:

- The company that handles Medicare claims in your area.
- Your local Social Security office. You can find the phone number and address by looking in the telephone directory under "Social Security Administration" or "U.S. Government".

U.S. Department of Health and Human Services
Health Care Financing Administration

Chairman STARK. There was $18 million provided in COBRA to implement the participating physician program, and there was, quote: "A significant portion of funds were to be used at each Medicare carrier to resolve billing problems of participating physicians."

I understand that the carriers have not received the funds for these professional staff people to help work this out. Do you have some plans to implement that part of COBRA.

Dr. ROPER. Yes. Since COBRA's passage in April through the end of last year we transferred $16 million from the SMI trust fund to carry out this function and are working with the carriers to do the various things that you all intended in the law.

Chairman STARK. It is also my understanding that we will hear later today from Blue Cross and Blue Shield that they have what they consider a number of practical suggestions to make participation more attractive and I would like to ask that somebody on your staff review these. If you are not able to be here then we will certainly send those on to you.

Dr. ROPER. Please do that.

Chairman STARK. I have to ask one major question that is not very comfortable for either one of us, but it is brought up to me. In dealing with the physicians, I have often said that this committee is in a position similar to that of a benefits committee for a major corporation or a major union. A benefits committee is able to negotiate under the preferred provider plans or under a variety of plans with doctors and strike a deal. So I would say to the physician, why cannot we? Aside from some of the political philosophy that gets involved, the doctors often say, we cannot trust you.

I go back to a couple of years ago when I became Chair of this committee. We were faced with a problem. I am not sure it was on your watch, but before I arrived the participating physicians had been promised an increase. Now, to me it was as much a contract as the Government can make.

Then the administration, for whatever reason, decided to freeze all fees instead of provide the increase to the participating physicians as promised. I think—and I would just like you to respond to this, that if we are going to strike a deal, whatever differences there may be between the administration and the Congress, if we must otherwise be perceived as negotiating in absolute good faith, we are not going to be able to negotiate.

I just wonder how you would respond to that observation, if you will?

Dr. ROPER. I think it is a fair observation. I continually hear—not just from physicians, but from everybody else in the health care industry with whom I deal—that they do not trust us. I think we could spend a long time going back and reciting the history of all of this, but the fact is they do not trust us and we need to be consistent and keep our word. I am doing my darndest to make sure that is the case in the agency now.

If we ask people to do things and tell them that if they do we will do something on a quid pro quo basis; if we do not follow through, then I think everybody has a legitimate right not to trust us. So we have got to perform.

I would just add, if I may, Mr. Chairman, that there are some helpful suggestions that we are continually getting, not only about this program but about a variety of things we do, both part A and part B, and I sometimes make light of that with my staff by saying, it is nice having so much help doing my job.

But I would make a plea to you, and to everybody really, for goodness sakes, unless there are things that strikingly need to be changed, let's try to keep things the way they are for a time here. A complaint I am continually hearing from everybody around is, let's stop the rate of change, or at least slow it down, and let's give everybody—in this case, the carriers—a chance to digest the instructions that we have given them and put the infrastructure in place before we make yet another change in things.

Chairman STARK. Okay. Now, you had the wind at your back. That was the underhanded pitch.

We want to encourage participation. And, basically for participation we are talking about money, and who gets the money, and how much.

That is something that I am much more familiar with than other sorts of issues that may come up in this, and it seems to me that we may have to hang out some bait, hang out the carrot.

Is it conceivable that you could join with us to prevail on OMB to suggest that we try to attract a small group to start. Initially it may cost us a little to entice people into the new system and to use it before, we begin to see the savings. If everything we do has to result in an absolute reduction, I do not blame people for not participating. I have got to offer them something.

Dr. ROPER. Sure.

Chairman STARK. We could offer quicker payment, which you and I now costs us lost interest. If we can stretch the payments out we save the Government money. On the other hand, if we can pay them quickly that makes some money for them.

Are you willing to consider some things that might initially cost us a little bit if we can together decide that maybe in the long run it will save us some.

Dr. ROPER. We are willing to consider them, yes sir.

Chairman STARK. That is great. That is all we could ask.

Mr. Gregg?

Mr. GREGG. Thank you, Mr. Chairman.

I would like to follow up on some of the numbers you were talking about earlier. You say 31 percent of the doctors are now participating and they represent 44 percent of the costs of the program, or they bill 44 percent of the costs of the program.

Dr. ROPER. Yes.

Mr. GREGG. And 71 percent of the costs of the program that are billed are now the full bill paid or——

Dr. ROPER. Paid on assignment, yes sir.

Mr. GREGG. Right, paid on assignment. So we are really dealing with a problem, from the billing standpoint, of 29 percent of the bills, or the dollars, anyway, that are being spent, right? Not being taken on assignment?

Dr. ROPER. Yes.

Mr. GREGG. Even though we only have 31 percent of the doctors participating?

Dr. ROPER. Right.

Mr. GREGG. That is, from a dollar standpoint and therefore, really from a service standpoint, only 29 percent of physicians billing amounts are exceeding the assignment rate?

Dr. ROPER. Indeed that is the case. The reason I am hesitating, if I could quibble with you, you said the problem is 29 percent. I do not view that as a problem.

Mr. GREGG. Well, I wanted to get to that.

Dr. ROPER. Okay.

Mr. GREGG. I wanted to talk about that 29 percent. Presumably 29 percent of the cases deal with people who may or may not have the financial capacity to pay more?

Dr. ROPER. May or may not. Yes.

Mr. GREGG. Seventy-one percent clearly deal with people who, even if they do have the financial capacity to pay more, are not going to have to pay more; right?

Dr. ROPER. That is correct.

Mr. GREGG. If you were to do a statistical analysis of the income of the Medicare recipients who are benefitting from this program, would it be reasonable to say that 29 percent of them were of moderate or high income level?

Dr. ROPER. Or course, that depends on your definition, but I think that is a round figure, yes.

Mr. GREGG. So that group of physicians who are now not getting paid under an assignment procedure could well be, if you were to match them statistically, could well match the group of beneficiaries that can afford to pay more?

Dr. ROPER. Could be, yes.

Mr. GREGG. So it seems like the system is moving in the right direction.

Dr. ROPER. It is not broken. That is the way I would put it, yes sir.

Mr. GREGG. And in fact a movement to mandatory assignment would potentially protect just the wealthy and the high income individuals in that 29 percent that is now having to pay more?

Dr. ROPER. It could have that effect, yes.

Mr. GREGG. Thank you.

Dr. ROPER. The general point I would make in answer to your questions, Congressman, is we believe the system as it now is set is succeeding and ought to be encouraged. We do not need fundamental change.

Mr. GREGG. Thank you.

Mr. DONNELLY [presiding]. Mr. Daub?

Mr. DAUB. Mr. Chairman, thank you.

Bill, it is good to see you. We appreciate your being here.

Dr. ROPER. Thank you.

Mr. DAUB. This subcommittee, particularly, watches all the work that you do, we think more closely than GAO, and I personally appreciate the work that your Department is doing to implement the area wage index modifications which are so important to our rural hospitals in Nebraska, and I hope you will continue to make sure that that goes well.

I hope that you will take a look at the Rural Health Care Coalition's set of legislation that has been introduced, to let us know as

soon as you can how you feel about that legislation and give us your views on whether it is appropriate, what difficulties you see, and where we might improve upon it.

We would like to try to have some hearings and move that legislation along. It would be my hope that that could be done some time this year.

Dr. ROPER. I would be pleased to do that.

Mr. DAUB. On two more parochial interests first, you are aware of course that we have serious problems in Nebraska with respect to our part A carrier from Nebraska, and our part B intermediary from Iowa. I am not going to belabor the point, but I just want to continue to urge you to keep the pressure on both of those fine organizations so that they will be above the 20 percent cutoff on the next go around.

We need them. We need to rely upon them for prompt and efficient turn around time in payments. Our hospitals, particularly with the rural nature of our State being affected more dramatically, than the largest cities, in our State which are taken care of by another company. Our rural hospitals, particularly, rely upon the Blue Shield and Blue Cross folks both in Iowa and in Nebraska.

We think we have seen some progress. Some improvements are occurring, but it is not enough yet. There are still a lot of problems out there and I hope you will keep their feet to the fire.

Dr. ROPER. I understand your points, and knowing that I was going to see you today I asked about it yesterday, and the message I got was what you just said. Things are improving but we are not there yet, though.

Mr. DAUB. Thank you.

Mr. Judd Gregg brought up a point that I think would be my evaluation and I want to emphasize I share his view. I look at Nebraska's number of participating physicians, 27.2 to 26.9 to 27.2 to 25.9. The numbers of physicians who participated has been rather stable over time, quite honestly.

But I look at the dollars, and we had a 30.5 percent participation. Then it dropped to 15.7, then to 15.2, and now it is back up to 22.7.

What do you suppose accounts for that very rapid drop?

Dr. ROPER. I would just be speculating. I do not know.

Mr. DAUB. Do you think it is the freeze that did it?

Dr. ROPER. The numbers I have are——

Mr. DAUB. Do you think the Medical Society out there put the word out? What do you think? Pretty dramatic do you not think?

Let's back up now. Maybe that is a good sign. Do you think the physicians think things are headed in a more stable direction now?

Dr. ROPER. Either that or they find it in their interest to become participating physicians whatever the stability of the system is.

Mr. DAUB. But there are not more docs participating, there are just more dollars going through the system now.

Dr. ROPER. The number I have in front of me is that 26 percent of Nebraska physicians are participating. That compares with 24 percent last year and 20 percent the year before.

Mr. DAUB. Compared to 27.2 when we first started.

Dr. ROPER. We must be reading from different numbers, but we are close, yes.

Mr. DAUB. I am reading from the wrong line. Excuse me, I am sorry. It is 25 percent, 20 percent, 23 and now 26. We are one of the 37 States that are up then, right?

Dr. ROPER. Yes.

Mr. DAUB. Okay. Well, a few more are in, but a dramatically larger number of dollars are in.

Dr. ROPER. That is right.

Mr. DAUB. I think a mandatory requirement would dramatically affect that. Like the idea of the freeze early on, I think that may have been the reason why there was such a dramatic decline in participation.

A number of physicians and physician groups have complained about the implementation of the maximum allowable actual charge, the MAAC program, mandated by the 1986 Budget Act. They cite the provision regarding new services under which physicians have had to reduce charges for services which were furnished prior to the base period if those services were not furnished during the base period.

There are also other coding related and administrative problems which have been identified. What actions have you taken or are you intending to take to address these and other issues regarding the MAAC provisions?

Dr. ROPER. Simply put, the MAAC program is extraordinarily complex. But to get to your specific point, we are dealing with these on a case-by-case basis, going back with individual physicians who did not bill during the base period and constructing a way to apply the MAAC to them.

We think that we have dealt with most all of those problems, but it is something that requires detailed work on an individual physician basis. This fall when we send out the notice that a new participating period is opening, we plan also to send out the MAAC notices to the individual physicians so they will have that data this time around to make a judgment as to whether to be a participating doc or not.

Mr. DAUB. When a doctor tries to get his MAAC table from his carrier so that he can take a look at the prevailing and reasonable charges and try to understand why his reimbursement has dropped this year compared to last year, what is the likely explanation for that? Is it because of the 115 percent rule? What is the reason why most physician's reimbursements today for part B have dropped in terms of actual dollars for a particular procedure or service compared to a year ago?

Dr. ROPER. Most commonly it is because of the base period and the technical issues you were alluding to in your earlier comments about physicians not actually charging in the base period, or some anomaly like that.

Mr. DAUB. Are there many appeals going on, much attempt to try to reorganize or reestablish? Have you got a lot of administrative activity in this particular area, or is it sort of sporadic or regional?

Dr. ROPER. We had a fair amount in the February/March period. That has trailed off now, but our carriers were very busy in that period answering individual doctor's questions.

Mr. DAUB. Mr. Chairman, thank you very much.

Mr. DONNELLY. Mr. Pickle?

Mr. PICKLE. Mr. Chairman, I do not have any questions.

I understand, Dr. Roper, you support the participating physician program——

Dr. ROPER. Yes sir.

Mr. PICKLE [continuing]. And it is working well and growing and we ought to continue to keep it as strong as possible?

Dr. ROPER. Yes sir, I sure do.

Mr. PICKLE. That is fine. Thank you.

Mr. DONNELLY. Mr. Chandler?

Mr. CHANDLER. No questions. Thank you, Mr. Chairman.

Mr. DONNELLY. Doctor, are you aware of the Massachusetts law that as a right to licensure physicians must accept assignment?

Dr. ROPER. Indeed.

Mr. DONNELLY. What do you think of that?

Dr. ROPER. For the same reasons that I oppose mandatory assignment nationwide, I do not think that is a wise law.

Mr. DONNELLY. Why?

Dr. ROPER. Because it has, over time, the very real potential of diminishing the choices and the access that the individual Medicare beneficiaries have.

Mr. DONNELLY. Has that happened in Massachusetts?

Dr. ROPER. I do not have any evidence that it has.

Mr. DONNELLY. Have you looked at it?

Dr. ROPER. Yes. Massachusetts has had historically one of the very highest levels of claims accepted on assignment, so forcing all physicians to accept assignment is only a marginal change for Massachusetts. It would be a very big change for other states.

Mr. DONNELLY. It would be a big change because there are less participating physicians?

Dr. ROPER. Yes, and fewer claims accepted on assignment by nonparticipating physicians.

Mr. DONNELLY. In the Massachusetts experience, have physicians left the state to practice?

Dr. ROPER. No, not to my knowledge.

Mr. DONNELLY. Well, why have you not looked at it?

Dr. ROPER. We are busy with other things, Congressman.

Mr. DONNELLY. You do not want to see its successes?

Dr. ROPER. No. I am willing to acknowledge that nothing much has changed in Massachusetts. I think the real question is, "Can that be generalized to other States?"

Mr. DONNELLY. There have been no draconian results because of the mandatory assignment.

Dr. ROPER. Because, as I said, Massachusetts had a tradition in place that was de facto mandatory assignment already.

Mr. DONNELLY. What percentage of your 30 percent participating physicians come from Massachusetts?

Dr. ROPER. I can give you the figure the other way around, what the Massachusetts number is for participation. Let me get that.

It is 44 percent of physicians in Massachusetts are participating doctors.

Mr. DONNELLY. In 1984, the House considered an amendment that would have mandated assignment. At that time the administration said it had no objection to mandatory assignment. Now, the

administration says they are vigorously opposed. What has caused the change of attitude?

Dr. ROPER. I do not know.

Mr. DONNELLY. Could it have been the one practical experience we have had in Massachusetts?

Dr. ROPER. I do not know the reference you make to 1984. This administration has been opposed to mandatory assignment all along.

Mr. DONNELLY. I just want to read something into the record.

Dr. ROPER. Sure.

Mr. DONNELLY. I would just like to read from the debate in 1984 when Mr. Jacobs was chairman of the subcommittee. He was the one that offered the amendment, and this statement he read on the floor is from the Office of Management and Budget.

I quote:

> The administration supports adoption of the Omnibus Reconciliation Act as yet further installment for the administration's effort to reduce the deficit. While the administration has reservation about the inflexibility of the physician assignment provisions of the Ways and Means Committee amendment, the administration nevertheless supports the adoption of the 1-year physician freeze which will save nearly $1 billion.

So you had reservations in 1984 and you have vehement objections in 1987. What I am asking you is, on what basis of fact or analytical data has the administration changed its position?

Dr. ROPER. We have not changed our position. What I think you are referencing there is the——

Mr. DONNELLY. Dr. Burke yesterday said in emphatic terms that the administration had very strong objections to my amendment on the catastrophic illness legislation.

Dr. ROPER. Sure. The point I was about to make is what you are quoting from is a comment about a complex bill that had a lot of provisions in the summer of 1984. The administration opposed mandatory assignment in the summer of 1984. We did then and we do now.

Mr. DONNELLY. What is your position on the appeal of the American Medical Association of the constitutionality of the Massachusetts law? Do you support that?

Dr. ROPER. Do you mean are we going to be a party to that suit one way or another, or my personal belief?

Mr. DONNELLY. Are you a party, No. 1, to the suit?

Dr. ROPER. No.

Mr. DONNELLY. Do you support the appeal?

Dr. ROPER. No.

Mr. DONNELLY. Are you opposed?

Dr. ROPER. We believe that mandatory assignment is not a good idea. The Commonwealth of Massachusetts is free to make those kind of judgments as it sees fit, even though we believe they are unwise, and we are not a party to that suit. States are free under a federal system to make judgments, even though the Federal Government may think they are unwise.

Mr. DONNELLY. As you know, there are pending before 17 State legislatures legislation similar to what Massachusetts has enacted. Are there any plans within your agency to do a detailed study and

look at the pros and cons, the positives and negatives of the Massachusetts experience?

Dr. ROPER. We do not have any, sir, no.

Mr. DONNELLY. Why not? Do you just want to make believe it does not exist?

Dr. ROPER. No. It is a matter that the States——

Mr. DONNELLY. Would you agree that it reduces the out-of-pocket expenditures of clients?

Dr. ROPER. It does, and it has adverse effects. It has significant adverse effects.

Mr. DONNELLY. Exactly what is the adverse effect? Can you list the adverse effect of the Massachusetts?

Dr. ROPER. No——

Mr. DONNELLY. You probably could not because you have not studied the Massachusetts experience and you have no intention to study the Massachusetts experience.

Dr. ROPER [continuing]. Because the Massachusetts experience is substantially different from the rest of the country because of the historical patterns of physicians in Massachusetts. It is quite different from the rest of the country.

Mr. DONNELLY. Could you be a little more specific on that point?

Dr. ROPER. Sure. Blue Cross of Massachusetts——

Mr. DONNELLY. I do not want to fight with the doctor.

Dr. ROPER. That is okay. It is a legitimate question.

Mr. DONNELLY. I see the Massachusetts experience answering all of the negative criticisms that are made against any sort of Federal mandatory assignment legislation and I just have not seen those bad things happen.

Maybe we are just a unique little island amongst the 50, but I think there are at least some other States that have similar geographic and educational and social experiences.

Dr. ROPER. Sure. The court in its opinion in *Massachusetts Medical Society* v. *Dukakis* found two unusual circumstances, as they characterized them, peculiar to Massachusetts which led the court to believe that this State law would not have an adverse affect. That is the point I was making earlier.

Let me be specific. They cited—the court did—that prior to the State law, 99 percent of all Massachusetts doctors were participating in Massachusetts Blue Shield, which has had a plan like the one that is now in place for Medicare since the 1960s. State physicians had also been choosing assignment on 90 percent of all Medicare claims, accounting for 94 percent of all Medicare charges.

My point is, to add the other 6 percent of Medicare charges under State law is not a big change and we are not likely to see a mass exodus of doctors or diminution of choice that is available to beneficiaries like you would have in a State where things went from 50 to 100 percent.

Mr. DONNELLY. We, if we had a national law, where would the physicians exit to?

Dr. ROPER. If you had a national law physicians would be compelled either to follow that law or get out of the Medicare program, and my point to you, sir, is that I am concerned that a fair number of them would get out of the Medicare program.

We have a program now—the participating physician program—which permits doctors and patients the legitimate choice of whether or not to go to a doctor who accepts assignment. I do not see that there is anything to be gained by depriving people of the choice of going to a physician who does not accept assignment.

Mr. DONNELLY. Well, I do not want to take up all the time, Doctor. I could not disagree with you more.

Dr. ROPER. I understand.

Mr. DONNELLY. I think what we are going to be facing is that more and more States are going to adopt the Massachusetts model and I think what we are going to have in this country eventually is a two-tiered system, but hopefully not a regionalized system.

Hopefully my good neighbors to the north will see the light and take benefit of the great good that it has done the retired people from the Commonwealth, but he and I could debate forever.

Again, I think HCFA has a responsibility to look at the Massachusetts experience and to closely monitor what is happening in those 17 other States.

Dr. ROPER. I take your point and we will surely do that informally. We have limited research dollars to do a detailed study.

Mr. DONNELLY. Well, I think you could do it in-house so that you keep a constant look on exactly what is happening in terms of health care to the elderly in this country, Doctor.

I just think that it is critically important that your agency, which is charged under the law to have responsibility in that area, ought to be looking at things that are being done that are affecting your client base and not to make believe that it is just a historical difference or it is just a unique experience, because I think it is an issue that is going to grow with public support.

There are many State legislatures that are going to have to be making choices and your agency maybe ought not to be directly involved in that at this point because you do not have the Federal legislative mandate which maybe you will have before this session of Congress is over, but you ought to at least be on top of the situation.

I thank you for coming, Doctor, and I appreciate the response to my questions.

Chairman STARK. Mr. Daub?

Mr. DAUB. Mr. Chairman, I have already had my turn, but I did want to tell the gentleman from Massachusetts that all of his colleagues have great admiration for the birthplace and the revolutionary spirit of Massachusetts.

Chairman STARK. Mr. Gradison?

Mr. GRADISON. Thank you, Mr. Chairman.

I regret that a commitment off the Hill made it impossible for me to be here at the beginning of the hearing, and I therefore do not want to cover ground that has already been covered.

I would like, however, Dr. Roper, to indicate my continuing concern about the question of prompt pay under Medicare. You may recall that Mr. Stark and I wrote a letter to the Secretary in November of last year objecting to the Department's plan to instruct contractors to withhold Medicare payment on clean claims until the 28th day after receipt.

The Secretary, in December, responded that would be no mandatory holding or delay of claims for this year, which is fine. I think that was a great way to leave it. There remains, however, some reason for concern, because we understand that such a delay is being considered. I simply wanted to use this opportunity to advise my colleagues on the committee, and you as well, that this is a continuing matter of very grave concern to me, and I very much hope that after consideration and reflection, the Department will decide to continue the policy which was spelled out in the Secretary's letter to us last December.

Dr. ROPER. Thank you, sir.

Mr. GRADISON. Thank you, Mr. Chairman.

Chairman STARK. Mr. Levin?

Mr. LEVIN. You say on page 7 that you are working hard to improve and strengthen the program. Just briefly, if you would, what will the program look like when it is successful? Just give us the measuring rod?

Dr. ROPER. I think it is successful now. I think continued improvement means a larger number of doctors and suppliers agreeing——

Mr. LEVIN. Just give us an idea in your own view what a fully effective program will look like.

Dr. ROPER. A fully effective program would be one in which every beneficiary in every locality of the country had the choice of a participating doctor.

Mr. LEVIN. Every beneficiary had a choice in every specialization?

Dr. ROPER. In every locality.

Mr. LEVIN. In every locality, in every specialization.

Dr. ROPER. I think we can have a successful program short of that, and we do now.

Mr. LEVIN. Okay. But that is a reasonable target?

Dr. ROPER. I said that is fully successful. That is the ultimate that we are striving for.

Mr. LEVIN. And how far are we from that today?

Dr. ROPER. I think most beneficiaries in every state have the choice in practically all specialties.

Mr. LEVIN. In every locality?

Dr. ROPER. Yes sir.

Mr. LEVIN. So you think we are essentially there?

Dr. ROPER. I think we have some room for improvement, but we have come a long way in the last couple of years.

Mr. LEVIN. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. If there is no further inquiry, Doctor, thank you very much.

Dr. ROPER. Thank you.

Chairman STARK. The next witnesses will comprise a panel: Manny Weiner, a board member of the Massachusetts Senior Action Council and Edward Carrig, a board member of the National Council of Senior Citizens.

Without objection, it has been the tradition of this committee to allow the administration witness to have as much time as they would like. What we will do, both for the witnesses now and the

Members, is run a time clock. So we will ask you to summarize or expand on your statement in any way you are comfortable, and at that point we will try and bring out more details of your testimony in the inquiry.

So you are Mr. Weiner?

Mr. WEINER. Right.

Chairman STARK. Would you proceed in any manner you are comfortable.

STATEMENT OF MANNY WEINER, BOARD MEMBER, MASSACHUSETTS SENIOR ACTION COUNCIL, INC., SOMERVILLE, MA

Mr. WEINER. My name is Manny Weiner. I am 72 years old and a resident of Arlington, Mass. I am a retired toolmaker, and I am here representing the Massachusetts Senior Action Council, a statewide grassroots organization with 5,000 dues paying members. I am a member of the board of this organization, which is a State affiliate of the National Council of Senior Citizens.

This organization is the consumer organization primarily responsible for the successful Massachusetts campaign to prohibit balance billing of Medicare beneficiaries. As you are all familiar with the practice of balance billing, the Massachusetts law requires all physicians, as a condition of licensure, to charge Medicare patients no more than what Medicare has determined is a fair and reasonable fee.

I am pleased to report what you have already noted, that the constitutionality of this law was upheld in the U.S. District Court of Massachusetts, and most recently in the U.S. Court of Appeals for the First Circuit. Also, you are aware that there are many comparable efforts all over the country to pass similar legislation.

Medicare has established a fee structure which it determines to be fair and reasonable. Unfortunately, under the present system the doctors can charge more than the Medicare reasonable fee. In 1984 these overcharges amounted to $2.5 billion on a national level. In 1987 they are predicted to be over $3 billion.

You have heard testimony that about 70 percent of the bills are charged with what Medicare considers fair and reasonable. This means that 3 out of every 10 bills are overcharged, and the average overcharge right now is $38 per bill that the patient has to pay out of his own pocket and no Medigap insurance will pay. These overcharges are creating greater out-of-pocket expenses for the Nation's elderly and handicapped citizens.

In this press release we sent you, I gave an example of a $600 overcharge in Massachusetts. I think it would be more appropriate and I think it would highlight one of the big problems of the participating physician program if I outlined to you how I became personally involved in this program.

I was the president of a local union and one day a retiree came to me with a bill for surgeon's services. We thought our insurance would cover for it, and this was the first time I heard of Medicare assignment. So I questioned the man and he said he went to his doctor and his doctor said he needed an operation.

So the man did what you and I would do. He says to the doctor, who would you suggest to operate on me? And he gave him the

name of the surgeon, the operation was successful, he was stuck with a bill that he did not expect and he had a hard time paying.

So then I went to the Social Security office and they explained to me what Medicare assignment was. So I said, what should he have done? They said he should have shopped around for a cheaper surgeon.

I said then, and I still say, that everybody is entitled to quality health care without worrying about the payment for that care. When someone is sick they should not have to worry about shopping around.

I would like to go into the Massachusetts campaign. In 1983 the overcharges in Massachusetts were over $20 million. They were a source of concern to senior citizens so we decided to do something about it. We filed legislation to restrict physicians to the fees that Medicare determined to be fair and reasonable.

At this time I would like to correct a statement made by the previous witness where he says that we have mandatory Medicare assignment in Massachusetts. Treating the patients under Medicare is voluntary on the part of the physicians. However, they sign an agreement saying that if they treat a Medicare patient, they will accept the payment as the fair payment in full.

In December of 1985 the Governor signed the legislation prohibiting Massachusetts' physicians, as a condition of licensure, from charging Medicare beneficiaries more than the reasonable charge allowed by Medicare. The legislation passed both branches of the Massachusetts legislature unanimously and it has been upheld twice in Federal court in the past year.

I would like to discuss something of common concern to all of us; what has been the impact of this legislative initiative? What has been the effect on the Massachusetts elderly and handicapped about this law? Have we been denied care? Have specialists stopped treating Medicare patients?

In rural areas where there is less competition among physicians have elders been hurt?

The answer to these questions is a resounding no. Over the last year there has been no evidence that access to health care has been limited. In fact, the opposite is quite apparent. Just last week we checked with the Massachusetts Board of Registration in Medicine, the Massachusetts secretary of consumer affairs, the executive office of elder affairs, and State legal service offices.

There have been no reports of elders being denied care as a result of this law. The impact has been quite the opposite. Massachusetts elders no longer avoid necessary physician services out of fear of receiving unassigned bills. We no longer have to shop around—a difficult task for seniors who are in poor health—for doctors who accept Medicare assignments.

We are now assured that no Massachusetts physician will charge in excess of the Medicare allowed fees. We expect that access for low income seniors who avoided physician services will now increase. The courts have also seen no reason to believe that access will decrease as a result of this law. Judge Robert Keeton, in his ruling upholding the Massachusetts law, stated:

In summary, I find that the plaintiffs have failed to prove that the effect of chapter 475 will be to reduce the access of Medicare beneficiaries in Massachusetts to medical care.

We feel this law is an important part of cost containment. We also realize that many States have conditions similar to those in Massachusetts. These States could enact similar measures without decreasing access for Medicare beneficiaries.

As was stated in the U.S. Court of Appeals decision:

A State would not normally wish to impose a ban that would hurt those citizens more than help them. An individual state may better be able to strike the balance between affordability and access in a way that best serves it older citizens.

We believe that a national ban on balance billing Medicare beneficiaries is necessary. The Massachusetts experience shows no access problems. If Congress is not prepared to pass such a law this year, it should at least encourage states to take the initiative and join Massachusetts in doing so.

This would be helpful in containing costs and increasing access for senior citizens. As elder consumers, it is our opinion that a Massachusetts ban on balance billing of Medicare beneficiaries has been a major step forward in assuring access to physicians for all elders and people with disabilities who are on Medicare. The routine practice of overcharging low income elders in excess of fees determined by the Health Care Financing Administration to be fair and reasonable is grossly unjust.

The Commonwealth of Massachusetts has wisely moved to eliminate the severe financial burden from the State's 820,000 Medicare beneficiaries. We urge the U.S. Congress to do the same for millions of Medicare beneficiaries nationwide.

[The statement of Mr. Weiner follows:]

STATEMENT OF MANNY WEINER, MEMBER OF BOARD OF DIRECTORS, MASSACHUSETTS SENIOR ACTION COUNCIL

My name is Manny Weiner. I am 72 years old and a resident of Arlington Massachusetts. I am a retired member of the United Steelworkers of America. I am here today representing the Massachusetts Senior Action Council, a statewide grassroots organization with 5,000 dues paying members. I sit on the Board of Directors of the Massachusetts Senior Action Council which is the state affiliate of the National Council of Senior Citizens.

The Massachusetts Senior Action Council is the consumer organization primarily responsible for the successful Massachusetts campaign to prohibit "balance billing" of Medicare beneficiaries. "Balance billing" refers to the practice of billing the patient for the difference or "balance" between what the doctor charges and what Medicare considers fair and reasonable. The Massachusetts law requires all physicians, as a condition of licensure, to charge Medicare patients no more than the Medicare determined reasonable fee. I am pleased to report that the constitutionality of this law was upheld in the U.S. Court of Appeals for the First Circuit. As you are most likely aware, comparable efforts are underway in as many as fifteen states across the country.

BACKGROUND

Elders who are balance billed, or receive Medicare unassigned claims, have been struggling with this problem since the enactment of Medicare in 1965. The passage of Medicare was brought about out of a concern for the amount of money that the elderly were paying for medical care. Unfortunately, in twenty-two years since the enactment of Medicare, the percentage of an elder's income spent on the costs of health care has increased.

Medicare has established a fee structure which it determines to be fair and reasonable. Unfortunately, physicians have had the ability to charge their patients more than the Medicare reasonable fee. In 1984, these overcharges amounted to $2.5 billion on a national level. Medicare beneficiaries had to pay this out of their own pockets. According to the Health Care Financing Administration, physician overcharges for 1985 increased by 16% to $2.9 billion. As of the last quarter of 1986, only 68.2% of all Medicare claims were assigned. Consequently, almost one out of every three Medicare bills was an overcharge in excess of the reasonable Medicare fee. We are aware of no Medigap policy that pays for unassigned claims. Therefore, the physician overcharges are creating greater out-of-pocket expenses for the nation's elderly, the very people the Medicare program was designed to protect.

In Massachusetts, the experience of Jack Hughes was not atypical. Mr. Hughes, a 70 year old resident of Watertown Massachusetts, fell on some slippery steps and broke his ankle. He was taken to the emergency room of a nearby hospital where his ankle was treated by a physician. Several weeks later, the physician sent him a bill for $1,200. Medicare determined that only $600 of this bill was fair and reasonable. Mr. Hughes was responsible for the remaining $600, a bill he had no way of predicting would be sent to him. These physician overcharges cost Massachusetts Medicare beneficiaries more than $20 million in 1983. The overcharges are an intolerable burden for elders living on fixed incomes.

With ever increasing overcharges threatening the financial well-being of seniors, the elderly leaders of the Massachusetts Senior Action Council decided that something needed to be done. It was decided that one approach to the problem of these costly overcharges was to restrict physicians to the fees that Medicare determined to be fair and reasonable. In December of 1985, Governor Michael Dukakis signed legislation prohibiting Massachusetts physicians, as a condition of licensure, from charging Medicare beneficiaries more than the reasonable charge allowed by Medicare. The legislation passed both branches of the Massachusetts legislature unanimously and has been upheld twice in Federal Court in the past year.

IMPACT OF THE MASSACHUSETTS LAW

So what has been the impact of this legislative initiative? Have physicians fled the state? Have elders been denied care? Have specialists stopped treating Medicare patients? In rural areas where there is less competition among physians, have elders been hurt? **The answer to all of these questions is a resounding NO!!** Over the last year, there has been no evidence that access to health care has been limited. In fact, the opposite is quite apparent.

According to The Massachusetts Board of Registration in Medicine, The Massachusetts Secretary of Consumer Affairs, The Executive Office of Elder Affairs, and State Legal Service Offices there have been no reports of elders denied care as a result of this law. The impact has been quite the opposite. Massachusetts elders no longer avoid necessary physician services out of fear of receiving unassigned bills. Elders no longer have to shop around, a difficult task for seniors with poor health, for doctors who accept Medicare assignment. Seniors are now assured that no Massachusetts physician will charge in excess of the Medicare allowed fees. We expect that access for low income seniors, who previously avoided physician services, will now increase.

The courts have also seen no reason to believe that access will decrease as a result of this law. Judge Robert Keeton, in his ruling upholding the Massachusetts law, stated:

> "In summary, I find that the plaintiffs have failed to prove that the effect of Chapter 475 will be to reduce the access of Medicare beneficiaries in Massachusetts to medical care."

The Massachusetts Senior Action Council feels the law is an important part of cost containment. We also realize that many states have conditions similar to those in Massachusetts. These states could enact similar measures without decreasing access for Medicare beneficiaries. As was stated in the U.S. Court of Appeals decision:

> "A state would not normally wish to impose a ban that would hurt those citizens more than it helped them. ...an individual state may better be able to strike the balance between "affordability" and "access" in a way that best serves its older citizens."

We believe that a national ban on "balance billing" Medicare beneficiaries is necessary. If Congress is not prepared to pass such a law this year, it should at least encourage states to take the initiative, and join Massachusetts, in doing so. This would be helpful in containing costs and increasing access for senior citizens.

As elder consumers, it is our opinion that the Massachusetts ban on "balance billing" of Medicare beneficiaries has been a major step forward in assuring access to physicians for all elders and people with disabilities who are on Medicare. The routing practice of overcharging low income elders in excess of fees determined by the Health Care Financing Administration to be fair and reasonable is grossly unjust. The Commonwealth of Massachusetts has wisely moved to eliminate this severe financial burden from the state's 820,000 Medicare beneficiaries. We urge the U.S. Congress to do the same for the millions of Medicare beneficiaries nationwide.

Chairman STARK. Thank you very much, Mr. Weiner.
Mr. WEINER. Thank you.
Chairman STARK. Mr. Carrig

STATEMENT OF EDWARD CARRIG, BOARD MEMBER, NATIONAL COUNCIL OF SENIOR CITIZENS, ACCOMPANIED BY KEN ANDERSON, BOARD MEMBER

Mr. CARRIG. Mr. Chairman, before we begin, I have a colleague here that came in with me yesterday morning on the red-eye special. Would it be possible for him to appear?

Chairman STARK. Anybody who would come all the way in on the red-eye and stay awake is more than welcome to appear.

Mr. ANDERSON. Thank you, Mr. Chairman.

Mr. CARRIG. Mr. Chairman, my name is Ed Carrig, and I am a board member of the National Council of Senior Citizens. I am also an executive board member of the Washington State Council of Senior Citizens represent the 8th Congressional District, of which Congressman Chandler is our Congressman.

Ken Anderson, my colleague here, is a board member of the National Council of Senior Citizens also and he is president of the Washington State Council of Senior Citizens. We want the committee to know that we are unpaid and unsalaried in these positions.

We also want it understood that we are not professional advocates and we are not salaried advocates, but that we are advocates for the senior citizens in the State of Washington.

With that, Mr. Chairman, we thank and appreciate very much the opportunity to speak before this congressional committee on what we believe are the abuses by the medical society and its members on the Medicare health delivery system.

Beginning in 1985 the Puget Sound Council of Senior Citizens of the National Council of Senior Citizens and Washington Fair Share became aware that medical doctors were not voluntarily accepting Medicare assignment. In Washington State in 1986 only 22 percent of the doctors voluntarily accepted Medicare's reasonable charge 100 percent of the time.

We began a campaign to increase the Medicare participation rate among physicians through individual calls and postcards. We appealed to the doctors requesting that they become participating physicians. Our appeals fell on deaf ears.

Subsequently we made contact with the King County Medical Society and then the Washington State Medical Association, asking them to use their good offices to encourage their doctors to accept the reasonable charge. We were rebuffed. Our direct appeals to the doctors failed.

In 1986, therefore, we introduced a bill in the Washington State Legislature mandating Medicare assignment for all doctors treating Medicare patients. By the time the AMA lobbyist got through amending the bill, including a means test, the bill that would have come out of the committee actually legalized that which we were trying to prevent. We had no alternative but to kill the bill in committee.

In the spring of 1986 the Puget Sound Council and Washington Fair Share were joined by the Washington State Federation of

Labor. Our strategy centered on placing an initiative before the State legislature. That initiative is now known as initiative 92. The ballot title is simple and direct: Shall it be a consumer protection violation for doctors treating Medicare eligible patients to charge more than Medicare's reasonable charges? Sanctions include civil fines, damages and injunctive relief.

To certify as an initiative to the legislature, you must first collect more than 151,133 valid Washington voters' signatures. Our initiative effort involved the hard work of hundreds of seniors and other volunteers on the street corners of Washington, the shopping malls, the fairs, the parades and other public gathering places to secure the needed signatures.

As a result of this effort and because of the tremendous interest in this legislation by seniors and others, almost a quarter of a million signatures were gathered by the deadline. The initiative was certified to the State legislature with the opportunity to pass it. It could not be amended. It could be passed. It would have become law if the legislature had passed it.

This initiative of the legislature prevented the doctors from amending our bill, so they copied our bill with the exception that they put in a bill that died in committee offering a means test to our bill.

On February 2 of this year over 800 seniors from throughout Washington State met in the rotunda of the State capitol to call upon our State representatives and senators urging passage of initiative 92. The AMA once again blocked our attempts.

Our initiative will be before the voters of Washington this November as it was certified on our initiative 92, with no changes whatever. Our struggle for equity and justice on Medicare bills will continue. We have spent the last two years fighting on behalf of the half a million older and disabled Washington residents who depend upon Medicare.

We must have protection against increasing medical costs. Earlier this year the New York Times reported that medical care costs rose 7.7 percent in 1986, far ahead of inflation and seven times as fast as the Consumer Price Index indicated.

We are concerned that doctors through their cupidity mandate that senior citizens give them a blank check. Medicare was not passed to provide a blank check to the doctors. The congressional intent of Medicare was to ease the burden of rising health costs and provide much needed access to care for seniors.

This has not occurred. Instead, Medicare has been a boon to the medical profession, enriching most of their members. According to the AMA, the mean net income for doctors in 1984 was $108,000.

The Medicare law must be strengthened. As doctors prices increase and with doctors' increasing refusal to accept assignment, many seniors neglect to get necessary medical attention because they cannot afford the luxury of preventive early health care. Once overcharged a senior citizen is less likely to return to the doctor who caused the overcharge.

The National Health Care Campaign in their report "Facing Facts" aptly summarized the state of Medicare by saying:

77-016 0 - 88 - 2

The safety net is tattered. Medicare covers only 45 percent of the average health bill, leaving seniors to pay an average out-of-pocket cost of $1,700, a higher proportion of income than the aged spent prior to the passage of Medicare.

I appeal to this committee to make Medicare something we seniors can depend and rely upon. In closing, the senior citizens of America deserve better treatment by the medical delivery system of this country. We seniors take great pride in the social and economic advancements we have made during our working years.

We want to be proud of America's medical delivery system and we believe that Medicare can provide the best medicine to millions of Americans, but first physician overcharges must be outlawed and costs controlled.

We join with our good brother here from the State of Massachusetts because their experience in Massachusetts is the identical experience that we had in the State of Washington.

Thank you very much, Mr. Chairman. Mr. Anderson and I are here to answer any questions you might have.

Chairman STARK. Thank you both very much. I am going to yield in a moment to Mr. Donnelly, who knows more about the mandatory assignment situation than I do, but Mr. Carrig, I have a question.

I gather that you had been willing to take a means test as was amended into your bill. How did they structure the means test?

Mr. CHANDLER. Would the chairman yield?

During your explanation you got real close to having it right. Let me clarify how this initiative works. It is called an initiative to the legislature, and with the appropriate amount of signatures——

Chairman STARK. I understand that.

Mr. CHANDLER. But it is important for you to understand that there was not the option for the legislature to amend their proposal. They could have offered an alternative, in which case both would have gone on the ballot.

Chairman STARK. Fine.

Mr. CARRIG. That is correct, sir.

Chairman STARK. I understand that. What I would like to know is what was the means test that was proposed. Can you describe generally what type of means test?

Mr. CARRIG. The means test generally was two times the poverty level, which would have come out to about $16,000.

Chairman STARK. For a couple?

Mr. CARRIG. Per——

Chairman STARK. The poverty level is $5,200 in round numbers.

Mr. CARRIG. $16,000.

Chairman STARK. For a couple?

Mr. CARRIG. I suppose so.

Chairman STARK. So what you are saying is that anybody below the poverty level?

Mr. CARRIG. Right.

Chairman STARK. And let's just assume for a minute that that is around $5,000 in the United States, maybe higher in Washington State. Then there would have been mandatory assignment?

Mr. CARRIG. Yes.

Chairman STARK. That would have meant that nationwide probably 30 percent of all Medicare beneficiaries would have qualified. What is wrong with that? You would have gotten a third of a loaf.

What was your objection to that means test, realizing it was not as good as having 100 percent? Can you comment on that?

Mr. ANDERSON. Mr. Chairman, the reason we unalterably opposed to a means test is that Medicare basically is an entitlement. It is an insurance program. How can we write an insurance program and deviate between the parties who are paying the same amount of premium and say, you are only entitled to ten percent but you get more?

Chairman STARK. Okay. I am with you.

Mr. ANDERSON. This is a very important issue.

Chairman STARK. This is what I am trying to get at. Why should they take assignment from rich people who can pay two or three times what a member of Mr. Weiner's union can pay? The argument will come back to us from the doctors that they are just subsidizing the rich who ought to pay more.

Now, we have two camps. If we could just come toward the middle. Certainly, I would be the last person to want to means test anything. What I am suggesting is if you set the means test high enough it is demeaning and a whole host of things that are going to get discussed.

I am just trying to find out if there was an easy way to determine who was above the cut and who was below it without having to have a scarlet A branded on your forehead. Might you take it for two-thirds of the beneficiaries?

We might get a lot closer to getting it if there was a way. I am not trying to badger you. I am just trying to figure out if there is some middle ground.

Mr. ANDERSON. No. I do not badger. Mr. Chairman, the medical profession at the present time are protesting the fact that they have all this paper work that they must do. Now, can you envision a means test in the State of Washington where we have an excess of 500,000 people who are eligible for Medicare care? Can you imagine that?

Chairman STARK. Yes. I will tell you. We are going to make it real easy for you. With any luck today we are going to pass some kind of catastrophic program which will adjust the premium according to income at some basis. I think that is likely to happen; if not today, it is on the way.

So a very simply way would be that you just carry with you the receipt from your premium, and if your premiums are below or above a certain level, that is almost prima facie of your means. So you could get a fairly simple way of doing it. I am not advocating it. I am just saying that if you could take the humility out and not have to have two colors of Social Security cards.

On the one hand I am trying to help the very low income people from getting gypped or imposed on. Maybe we have got to turn around and say, well, if your income is above $100,000 you ought to help the poor docs along.

Now, clearly, and you hit on it, it would be onerous paper work. It would be demeaning to have to come in and bare your soul to say, I am poor, do not charge me.

Can you conceive of a way where we could have some kind of a relationship to income and perhaps get half or two thirds?

Mr. Wiener is shaking his head no. You do not have to in Massachusetts.

Mr. WEINER. No. Could I answer that speech?

Chairman STARK. Sure.

Mr. WEINER. We considered that. That was one of the arguments raised in Massachusetts. First of all, we have a Medicaid program which affects poor of all ages. Second of all is, we have a fair and reasonable fee schedule set up by Medicare. When a millionaire and I go to the corner store and we buy a newspaper, the newspaper guy does not say to the other guy, you are a millionaire, I am going to charge you more.

I think that Medicare administration, their job is to set up a fair and reasonable fee which we want to pay. But just because a man is poor, when we go to a grocery they do not ask us how much money we make or whether we are unemployed. They charge the unemployed man exactly the same as the rich person. So I am against a means test of anything and I just want to emphasize that.

Chairman STARK. You know the reason Massachusetts has good laws? It has got so many articulate people who can explain them right. That is what I like.

Mr. WEINER. Well, I do not know. This is a big subject with us. We do not want a means test but I will tell you what, the poor have been covered by Medicaid, and that is the program.

Also, speaking as a senior, we do not want to go and be humiliated by saying, well, you have got to give me a cheaper rate because I make less.

Mr. CARRIG. Mr. Chairman, in the State of Washington when they raised this question of the means test, we testified before the committee our opposition to the means test. Social Security and Medicare are insurance programs rather than charity programs, and when you allow a means test into an insurance program, it destroys the insurance program, the relationship.

Say we follow this out and we put a means test on our automobile insurance, we would not have an insurance program.

Chairman STARK. Well, let me suggest—free advice is worth what you pay for it—but a strategy. I would submit to you, that when a guy is pushing on the door real hard, sometimes you can just step back real quick and they will fall in on their face.

If you think the doctors are complaining about paper work now, see how many doctors could fill out a balance sheet and have it add up properly, much less analyze one and come up with a test. Say okay, doc, you figure it out, and boy you would win. There is not one in a thousand who can add their own checkbook up, much less tell you what you ought to pay. I would say, go ahead, let them try. But maybe that will not come to pass.

Mr. Daub.

Mr. DAUB. Mr. Chairman, I would defer. I have some questions but my two other colleagues each have a witness here from their own State and I would certainly defer until they are finished.

Chairman STARK. Mr. Chandler.

Mr. CHANDLER. Thank you, Mr. Chairman. Mr. Carrig and Mr. Anderson, did you happen to be machinists? Did you work for Boeing by chance?

Mr. CARRIG. Yes, and I think that, as mentioned by the chairman, that T. Wilson, the president of the company, and myself negotiated the first health and welfare program of the Boeing Co., and I think that we were the greatest friends back in those days when we negotiated, that the Washington State Medical Association and the King County Medical Association had, because we placed all of those employees on those systems.

Mr. CHANDLER. I agree. I think that you would be hard pressed to find a company that has a better employee benefit package than the Boeing Co., and many of the other major employers in our State.

Mr. CARRIG. I agree with you.

Mr. CHANDLER. The reason I asked you that is I thought that I remembered you. I think that consistency is something that is at least worthy of considering in issues like this, and as you know, much of the work that the Boeing Co. does is federally funded through military contracts.

Correct me if I am wrong, but it is my recollection that when the issue of reimbursement for military contracts comes up there have been two bitterly divided positions, one on the part mostly of the Air Force suggesting that there be a limit on the reimbursements for salaries for workers, that there be a cap there, sort of a mandatory assignment for employees of the Boeing Co., if you will.

The position of the unions involved has been bitterly opposed to that notion. They say they have got to be free to establish their own salaries through negotiations and collective bargaining. This puts you in the position, it seems to me, of being somewhat inconsistent in your demand on the one hand for mandatory assignment for physicians, while on the other hand, for a federally funded program, saying no, we do not want—even if there is the benefit of somewhat lower Federal expenditures—to have the rates of reimbursement determined by the Congress of the United States.

Mr. CARRIG. Well, Rod, let me tell you how the program came about, the health and welfare program of the Boeing Co. We were in negotiations and we requested a health and welfare program paid for by the company, and the company said look, there is a 12-percent increase on the table. Now, if the union wants to take a health and welfare program out of that 12 percent you can do anything you want with that 12 percent.

So that did not come from the company and tacked on. That came out of the wage increases, and the subsequent wage increases, of the workers at the Boeing Co.

Mr. CHANDLER. That is a little bit different subject than what I was talking about, and I agree, compensation is usually a package and some level of that will be employee benefits, and the size of the level is one that is usually bargained collectively and that is appropriately the way it should be. I was talking about the Federal reimbursement for contracts.

Mr. CARRIG. But you see, that Federal reimbursement was from wages and it came out of our wages, and we reminded the company that in the future if a national health program came into effect we

would expect the company to reimburse the members of the union for their lost wage increase. And then those benefits then were passed on to the other nonorganized members of the Boeing Co.

Mr. CHANDLER. Has there been a lack of physicians who have accepted assignment in the State? Have seniors found it difficult to find physicians who have accepted assignment?

Mr. CARRIG. Well, 78 percent of the doctors in the State of Washington refuse voluntary assignment. The 22 percent of the doctors that do accept assignment I would say are those physicians in the State of Washington that are under HMO, health maintenance organization facilities.

So I really cannot say, Congressman, what the number of physicians are in the State of Washington who accept voluntary assignment.

Mr. CHANDLER. I see I am out of time. Mr. Chairman, I appreciate the opportunity to ask these questions. Perhaps we can get some written responses on some of these other issues as well.

Thank you, sir.

Mr. CARRIG. Thank you.

Chairman STARK. Mr. Donnelly?

Mr. DONNELLY. Thank you, Mr. Chairman.

Manny, where do you live in Massachusetts?

Mr. WEINER. I live in Arlington.

Mr. DONNELLY. Arlington. So I am not your Congressman?

Mr. WEINER. No.

Chairman STARK. Tip O'Neill is not anymore either, is he?

Mr. DONNELLY. No, it is Joe Kennedy, right?

Mr. WEINER. Right.

Mr. DONNELLY. Have we ever met before?

Mr. WEINER. No.

Mr. DONNELLY. Now, I am just saying that so that members of the committee and staff will know—[Laughter.]

Chairman STARK. Do you want to go off-the-record? Is that where you are coming from?

Mr. DONNELLY. No. I just want you to know that there is no relation between Manny and I and think it is important to put this on the record because of the response I received from Dr. Roper, the Administrator of HCFA.

It seems as if HCFA wants to make believe that the Massachusetts law and the Massachusetts experience and the data and the facts that have been shown does not exist, and our friends from Washington come in here today—and I think there are 17 other pieces of legislation in state legislatures across the country where this issue is going to be addressed.

Now, maybe they will not all copy the Massachusetts experience, maybe it will be somewhat different, but I am astonished that HCFA would not have a working group, minimally, inside the agency to keep close monitoring on the successes or failures of the Massachusetts experience.

But let me just ask you this, Manny. How many physicians have fled the State since Governor Dukakis signed the mandatory assignment law? I mean, is the number of registered physicians up or down?

Mr. WEINER. Well, first of all, as of April 1986, according to our attorney, 1,025 new physicians became participating physicians in the Massachusetts program. In the same time, 15 dropped out.

Mr. DONNELLY. And the total number of licensed physicians in Massachusetts has increased by almost 400 to 500.

Mr. WEINER. Right.

Mr. DONNELLY. So there has been no mass exodus across the border to New Hampshire, the Live Free or Die State. I mean, it just has not happened, Manny, correct?

Mr. WEINER. Right. There has been no mass exodus. But I will tell you what is very revealing and maybe the committee would be very interested in it.

I was participating in the Governor's Conference on Aging last Monday and a woman doctor from Northampton spoke, and she is leaving the private practice—she is a very sincere and devoted woman, and the head of the Massachusetts Hospital Association was there listening to her also—and the reason she is leaving is she feels that under Federal restrictions she feels that she cannot give the patients the quality care they deserve. She has taken an administrative job in the University of Maine.

Mr. DONNELLY. That is not the State legislation that is making her leave, it is rules and regulations promulgated by HCFA.

Mr. WEINER. Right. No doctors are leaving the State because of the cap on Medicare fees, period. And as I said, we are a statewide organization. Just last week I talked to Paula Gold about it, whether she got any complaints or anything like that.

Mr. DONNELLY. Let me ask you about the rural parts of Massachusetts, like there are up in western Massachusetts. It is extremely rural and very agricultural.

Mr. WEINER. We have had no complaints.

Mr. DONNELLY. And in rural areas where there is less competition amongst physicians, have the Medicare clients been hurt?

Mr. WEINER. We have had no complaints, and I checked with the Secretary of Elder Affairs. Sometimes the complaints are referred to them. There are no complaints to the board of registration of medicine which licenses doctors. We have had not a single complaint about doctors refusing to treat the elderly, about access.

Mr. DONNELLY. What about specialists, Manny. Have you seen specialists, because of the mandatory assignment legislation, drop out of treating Medicare recipients in Massachusetts?

Mr. WEINER. No. We have had no reports of any.

Mr. DONNELLY. Many physicians say that there is no need for legislation of the type that we have adopted in Massachusetts because they can be trusted not to extra-bill low income patients. What is your response to this claim? In other words, if somebody walks through the door and they are living on basic Social Security subsistence and they know it and they have a relationship with that patient as opposed to a former president of Boeing or a former Congressman coming in?

Mr. WEINER. The House Select Committee on Aging under Congressman Edward Roybal of California investigated that a couple of years ago, and they published a scathing report, and I can quote it. They said the senior with an income of less than $5,000 a year is

overcharged practically to the penny as much as the seniors with a much higher income.

This is a report published by the House Select Committee on Aging, I think 1984 or 1985.

I would also quote the Massachusetts experience in this way, and I would like to correct the record a little. In 1984, before the Debt Restructuring Act of 1984 was passed and everything, in Massachusetts 78 percent of the bills in Massachusetts were accepted as payment in full on a voluntary basis. At that time we passed Senate bill 2243 which mandated that the seniors who had MEDEX—which is the Blue Cross Blue Shield thing for seniors, right—MEDEX coverage could not be billed more than the Medicare fee.

Approximately half a million of the 800,000 seniors in Massachusetts were covered because they had MEDEX. Approximately 100,000 were under Medicaid. So the rate of compliance went up to the 91 percent that was quoted in the Federal report. That means 9 percent were being overcharged. Now, the 9 percent, according to my figures, were the 200,000 seniors who could not afford to buy Medigap insurance, because practically everybody in the state who can afford Medigap insurance buys MEDEX.

So I say—and I agree with the Roybal report—unfortunately the very poor are being overcharged as well as the more wealthy seniors.

Mr. DONNELLY. Manny, you and I are running out of time.

It is not as Democratic down here as it is back in the Commonwealth, but let me ask unanimous consent to have included in the record an analysis I had done from the Congressional Budget Office that would show that the adoption of mandatory assignment legislation on the Federal level would reduce the out-of-pocket expenses for the Medicare clients by $5 billion.

Chairman STARK. How often?

Mr. DONNELLY. Every year. And the adoption of my amendment yesterday which simply dealt with mandatory—had it been adopted, had the committee in its wisdom adopted my amendment—just on mandatory assignment on catastrophic coverage would have saved out-of-pocket expenses on a yearly basis of $938 billion, if I could have that included in the record?

Chairman STARK. Without objection.

[The information follows:]

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, April 29, 1987.

MEMORANDUM

To: Tom Barker.
From: Sandra Christensen.
Subject: Enrollee Savings from Mandatory Assignment Under Stark-Gradison Plan, 1989.

As you requested, I've simulated the per-enrollee and the aggregate savings on balance-billing costs that would accrue to SMI enrollees under the Stark-Gradison plan, under two alternatives:

Mandatory assignment on all charges for physicians' and related services claimed under the Supplementary Medical Insurance (SMI) program; and

Mandatory assignment only on charges for physicians' and related services that would be above the SMI copayment cap (which would be $1,043 in 1989).

With mandatory assignment on all charges, aggregate savings to enrollees would total an estimated $5.1 billion in calendar year 1989, with per-enrollee savings of $157. These savings would be realized entirely by non-Medicaid/Medicare enrollees, because all Medicare claims are assigned for Medicaid/Medicare enrollees. The estimated savings for non-Medicaid enrollees would be $176, on average, in 1989 (see Table 1).

If manadatory assignment were required only for claims submitted for services to enrollees who had already exceeded the SMI copayment cap, aggregate savings to enrollees would be an estimated $938 million in calendar year 1988, with savings of $32, on average, for non-Medicaid enrollees.

I hope this is helpful.

TABLE 1.—ESTIMATED SAVINGS TO ENROLLEES FROM MANDATORY ASSIGNMENT UNDER STARK-GRADISON PLAN, 1989

	CY 1989
Mandatory assignment on all charges:	
Per enrollee savings (in dollars):	
All enrollees	157
Non-Medicaid enrollees	176
Aggregate savings (in millions of dollars)	5,091
Mandatory assignment on all charges above the SMI cap:	
Per enrollee savings (in dollars):	
All enrollees	29
Non-Medicaid enrollees	32
Aggregate savings (in millions of dollars)	938

Source: Congressional Budget Office.

Mr. DONNELLY. And one last thing. Let me congratulate you both for coming here. Your organization has been very outspoken on this issue. Again, I would like to say for the record, I have become somewhat puzzled or concerned that some of the other senior citizens organizations have not been so outspoken on this issue—for example, Mr. Roosevelt's group and AARP—as your organization has, and I congratulate you folks for doing that, and I question why that is when you see the dollar savings that your constituents and our constituents on Medicare recipients would save. It is puzzling.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Daub?

Mr. DAUB. Thank you, Mr. Chairman.

The college student loan program is income related, or means tested. They are not all poor people. It even takes into account whether you have more than one child in college at the same time.

The Social Security program, the old age and survivors program, the main trust fund upon which we all rely on the first of the month, is income related, it is means tested. It says if you make over $25,000 of adjusted gross income that you add up to half your Social Security to that for tax purposes. In other words, we are taxing part of Social Security, or if you earn over $32,000 on a joint return. That is an income related test.

And, of course, Medicaid is income related, is it not? It is a means tested program. So when the chairman indicates that there is a time when you stop pushing on the door—I remember a story of a commanding general when I first got in Korea, and all the "shave-tails" were lined up there in the room waiting and here comes the star and he said, I want to make it perfectly clear what second lieutenants remind me of, people who go through life push-

ing on doors marked pull. Well, he made himself perfectly clear. I guess we all knew where we stood.

Our problem is trying to keep safety and soundness and solvency a part of these trust funds—the Medical fund, the disability fund, old age and survivors—commencing to look at this very dramatic change in the elderly demographics that you all are very much aware of.

We are an aging society. We are adding a million people a year to the over-65 ranks. You are in the forefront of leading the battles for focusing State legislators and Members of Congress' concerns, what we ought to be thinking about as we see this dramatic shift and these rapidly growing numbers.

We here have a public policy problem in that we have to think about how we pay for all of this, but I find most senior citizens, most older Americans, most mature adults also very genuinely concerned about what their kids and their grand kids are going to have to pay as well. So we have cost of living escalators, indexers, COLA clauses.

We have the question of productivity in the workplace so that we can be paying in at rates that balance with the payouts as we live longer, and I do not think it is unreasonable for the House now in this catastrophic health insurance debate that we are having—we are going to start our markup again at 3 o'clock this afternoon—to be arguing whether in some way we income relate what we are going to do about enhancing the benefits in part A and part B.

I am troubled about having to go in that direction, but I also want to be sure we keep safety and soundness and solvency, that what we do have is that safety net out there of the security of what Social Security and Medicare and Medicaid do mean to our older adults. With that in mind then I get concerned about the two States that are here today.

I think it is a great debate that you are allowing us to have. Your input is valuable. One State with a very good success rate on mandatory assignment—well, I suppose it is easy to balance the budget if you raise taxes too, rather than talk about the agony of the more painful way, and that is trimming spending—but you are very well organized now in your State as a result of that.

In your State the sign-up is very low, and what I would worry about the most—and I say this sincerely to my colleague, Mr. Chandler, what happens in a State where—your State sign-up participation was very high when the law was passed. At least that is true compared to this State where the sign-up is low and if we would implement mandatory assignment in your State I wonder whether you have any concern about doctors just deciding not to deliver health care to sixty-fivers and older.

Would there be any fear on your part that maybe the quality and/or the availability of health care would deteriorate or decline? Because there seems to be a pretty adamant physician's opinion about this in your State with the low participation now, if you mandate, and their State had a high participation when it was mandated in the first place, so I am not sure they were really risking as much in terms of what I am asking you to answer, as your folks might be, and I would honestly like to know what your opinion is.

You have been in the trenches working on this thing for a long time. What do you think about that?

Mr. CARRIG. Ken would like to answer that question, and then I will follow up.

Mr. DAUB. Fine. Mr. Anderson.

Mr. ANDERSON. We do not believe that the Washington Medical Association members are going to throw aside what basically is 35 percent of the average income of the average doctor in the State of Washington. We have figures predicated in 1984 which showed us that $265 million was paid in Medicare benefits in the State of Washington. This is only 80 percent of the 100 percent that Medicare determines is a fair and reasonable charge.

Mr. DAUB. But you think they are so motivated by money, that is so much of their livelihood that they just will have to like it or lump it?

Mr. ANDERSON. We are led to this conclusion to a degree when we hear information to the effect that we may not be able to give you the service we have in the past if we are forced to accept Medicare assignment. We do not believe this.

But to carry my deal through, actually, the figures that we have, to the $265 million you have got to add $66 million for the additional 20 percent that is paid by the individual or by his medigap insurance.

On top of that, during that period of time there were overcharges in the amount of $64 million. So we are looking at a total figure in excess of $395 million.

Now, we broke this down on an average for what we think is the number of physicians in the State of Washington, and we come out with a figure that is just under $36,000 a year. According to the AMA's on——

Mr. DAUB. Per doctor?

Mr. ANDERSON. Per doctor, on an average. According to the AMA's own statement, the average doctor in the State of Washington earns in excess of $100,000. So we still come back to the point that in excess of 35 percent of the average doctors income in the State of Washington comes from Medicare.

Mr. DAUB. Do you have very many HMOs in your State?

Mr. ANDERSON. We have one very large one, we have a few small ones, and we have a few PPOs, but the big one we have is group health which operates across the State now.

Mr. DAUB. Incidentally, does that seem to have helped stabilize health care cost delivery for the older participants; can you tell?

Mr. ANDERSON. Not necessarily, because they have come out and raised the premium that they are charging these people. In fact, at the present time there is a program that has been put into effect by the King County Blue Shield in which they are going to categorize the retired people. People 65 to 70 will pay x amount more, 70 to 75 will be a higher premium, and this indicates to us that——

Mr. DAUB. Not means tested or income related, but looking at the greater risk and more expense as you get older and your illness gets more intense.

Mr. ANDERSON. I am 76 years old so it is going to cost me two brackets above what the guy 65 pays.

Mr. DAUB. Are you 76?

Mr. ANDERSON. Yes, sir.

Mr. DAUB. Boy, I would not have guessed that; maybe 56.

Mr. ANDERSON. Thank you very much.

Mr. DAUB. Let me tell you that my time is up, fellows. I need to try to learn one other thing and I will be seeing if we cannot get this in writing from you.

Mr. CARRIG. Is it possible for me——

Mr. DAUB. If the chairman would allow me just another minute here to let this gentleman answer?

Chairman STARK. Go ahead.

Mr. DAUB. Yes, go ahead.

Mr. CARRIG. I am a member of a group health cooperative of Seattle and the Puget Sound area.

Mr. DAUB. Is that the biggest one?

Mr. CARRIG. That is the largest.

Mr. DAUB. Okay.

Mr. CARRIG. I belong to it and its predecessor for the past 46 years, before it was medical security, and that was the only option you had at the Boeing Co.

Mr. DAUB. I see. That is what that one principally is, is the Boeing community?

Mr. CARRIG. That is right, and it is an HMO and my wife and I—that includes all of the medicine also for the co-op members, and it is very successful. We were raised about three months ago, but just a certain group within it as an experimental basis.

So I wanted to say to you, Congressman, that we share your concerns about the financial integrity of Medicare programs and we suggest to this committee that some of the abuses that occur by the medical profession in Medicare should be corrected and the inflationary rate of the doctor increases—in the past 10 years they have gone up 3 to 4 percent above the other inflation or cost-of-living adjustments in our economy.

So we think the abuses and the unprecedented raises in the doctors costs in that past 10 years at that rate is inexcusable.

Mr. DAUB. I want to just conclude by saying that I appreciate you both being here. I listened, as I read your testimony as well. This committee has your concerns in mind. We appreciate the dilemma we face together, obviously. We are in agreement on that.

I want to make it clear that free medicine, not the kind some people want, will never be cheap. And if we look at the health care systems of all of the other countries of the world, no matter how they are configured, we have seen technology explode into our health care systems in this world, particularly in the United States.

It has given us longer lifespans and the technology that we have seen in the past 10 years will not even be comparable to the technology that is coming into the marketplace for health care delivery in the next 10 years. It will just be revolutionary in comparison, and it is going to be expensive.

I do not think we want to deny, so we say the doctors are the problem. Let me say that one of the biggest problems with the rapidly rising health care costs in America is simply technology, because if you do not have state-of-the-art in that HMO then they

cannot get their liability insurance so that you can get that state-of-the-art.

So there are other things besides doctors that are involved in the equation of the expense, and I want to put that on the record and make sure. We can talk about this afterwards, okay.

Mr. Chairman, thank you very much.

Mr. CARRIG. Mr. Chairman could I make one conclusion?

Chairman STARK. Go ahead.

Mr. CARRIG. We want you to understand that the half a million—500,000—Medicare recipients in the State of Washington are nonpartisan. It hits Republicans, Democrats, Independents, and all the political colorations are in that half a million, so this should be a really nonpartisan issue and should not divide us on a political basis.

Thank you very much.

Chairman STARK. Thank you all. Your testimony is very helpful and we appreciate your taking the time, particularly coming out on the "red-eye". That is love's labor.

Our next panel will consist of Mr. Ronald Pollack of the Villers Advocacy Associates, Washington, D.C.; Dr. Jerry Cromwell of the Health Economics Research Corp.; and Mr. William Newsom, the executive vice president of Blue Cross and Blue Shield Association of Kentucky.

Gentlemen, if you would like to proceed in the order which you appear on the witness list, without objection your entire testimony will be made a part of the record, and if you would summarize and expand on it in 5 minutes, we will then try to inquire and see if we can get into a more general discussion of the issues that you will cover.

So Mr. Pollack, if you would like to proceed.

STATEMENT OF RONALD F. POLLACK, EXECUTIVE DIRECTOR, VILLERS ADVOCACY ASSOCIATES, WASHINGTON, DC

Mr. POLLACK. Mr. Chairman, before I focus on the subject at hand, I just want to thank you and the ranking minority member and the subcommittee generally for your leadership on the catastrophic health care bill. I know you still have some unfinished business to undertake this afternoon, but I particularly wanted to express my personal appreciation for your work on the buy-in provision that is protecting the low-income beneficiaries as well as your effort to keep the basic premium down.

That really has been our concern all along because we want to protect low-income people, and I really appreciate the leadership you have given.

Chairman STARK. Mr. Pollack, without objection you will be recognized for another hour or two if you would like to go on in that same vein. Thank you very much.

Mr. POLLACK. I am joined by Judy Peres, the health policy director for our group.

The current Medicare system as it pertains to assignment provides maximum discretion to physicians. Currently about 68 percent of all claims are assigned.

However, this figure includes claims for services provided to beneficiaries who are both participating in Medicare and Medicaid, the so-called cross-over claims, and of course, Medicaid requires those claims to be paid on an assigned basis.

When cross-over claims are excluded, the actual assignment rate is estimated at between 48 and 53 percent. Now, the percentage of physicians—who are participating physicians—who are accepting assignment on a 100-percent basis—is now approximately 28.4 percent.

Chairman STARK. Excuse me.

Mr. POLLACK. Yes, sir.

Chairman STARK. Just to keep me comparing apples and apples here, you are saying that the assignment rate, if you eliminate those where it is mandatory assignment anyway, you are down to 50 percent?

Mr. POLLACK. That is right. It is in the range of 50 percent.

Chairman STARK. Can you tell me how much of that 50 percent is accepted by PARs?

Mr. POLLACK. I do not have that data. I am sorry.

Chairman STARK. It would be an interesting number, if you could find it later. Thank you.

Mr. POLLACK. The participating physician program, we believe, has had a favorable impact on the assignment rate, although that impact appears to have reached its apex and is no longer producing additional favorable results from its first year.

Indeed, the participating physician rate fell from 30 percent in 1985 to 28.4 percent in 1986. In other words, we have had a drop of a little over 5 percent of participating physicians who have now dropped out of the participating physician program.

Beneficiaries generally have had much difficulty choosing a physician on the basis of price, and they have also had difficulty determining which physicians accept assignment. This problem remains even though there are supposed to be directories available that would facilitate that information. However, we have received a good deal of information from groups around the country who have experienced tremendous difficulties in getting the directory. Often there have been delays of 3 or 4 months, or even more.

But even in places where the directory appears to be available, I think it is safe to say that the overwhelming majority of seniors do not know about, and have never received, a directory.

Now, given the fact that there are very substantial doctors' bills that seniors must bear, we have seen in State after State, particularly on the grassroots level—and now I am not talking so much about national senior organizations but more about local organizations—that Medicare assignment has become a priority issue among seniors around the country.

They have manifested this priority concern through a variety of different ways. Most groups started to work on this issue by contacting physicians individually as well as local medical societies. Some groups, such as the Illinois State Council of Senior Citizens, tried to bring the issue to the attention of the media by issuing Medicare assignment reports county-by-county in the hope that this would put pressure on the doctors and their organizations to accept assignment.

In Colorado, the United Seniors of Colorado, an affiliate of the National Council of Senior Citizens, tried the carrot approach. They held an awards dinner for those physicians in the community who accepted assignment. In other places efforts were made to publicize in the newspaper those physicians who are not accepting assignment.

In any event, some of these efforts were successful. In fact, in some places there were negotiations undertaken by some of these local senior groups so that deals could be worked out with hospitals. Under those arrangements, the members of a particular organization would go to a particular hospital where the physicians in that hospital agreed that they would accept all patients on an assigned basis.

These efforts helped somewhat, but by and large this was a hit-and-miss approach. As a result, there has been a substantial amount of activity to promote State legislation.

I will try to summarize these activities for you. On page 15 of my written statement I have a chart that provides you with an indication of what is happening around the country in these various State efforts. Now, as you can tell from the description in the chart on page 15, you will see that many States, following the Massachusetts example, are now trying to implement some variation of the Massachusetts legislation that was enacted fairly recently.

To date, no other State has enacted any comparable legislation, although there are some States that are moving well along. For example, in Vermont, one house of the State legislature has passed legislation and the other house has reported a bill out of its authorizing committee. The pieces vary somewhat, but it is modeled to a large extent after the Massachusetts legislation.

You will see that there are different variations of the proposals themselves. For example, you heard the variation from the State of Washington where it would be a consumer protection violation to fail to accept Medicare assignment. In some places there are means tested approaches to this. As you see, Connecticut is one such place. Vermont is another such place.

Florida, I think, has a very interesting example that I would hope the committee looks at a little more closely in the future with respect to any potential national legislation. I think, by the way, that the Florida variation gives us a clue to a question that the chairman asked before: why is it that some of the national groups oppose mandatory assignment while others support it?

Those senior organizations that have opposed mandatory assignment have been fearful that some doctors are going to drop out of the Medicare program altogether if assignment is mandatory. I know that in our discussions with the AARP, for example, that has been one of the concerns that they have raised and one of the reasons that they have not been supportive of mandatory assignment modeled after the Massachusetts or comparable legislation.

What the legislation pending in Florida seeks to do is to take the Massachusetts approach, but to create some exemptions and to create those exemptions based on those communities in the State that are medically underserved.

The fear was that in those areas—typically rural areas—where there are fewer physicians and where the supply and demand is

really not at a good point from a beneficiary standpoint, that some doctors might opt out of the Medicare program.

So what the pending Florida bill is, in effect, saying; Let's adopt this assignment approach, but in those areas, however they determine this index, that are medically underserved, we are going to create some exemptions from the assignment mandate.

I do not know whether the Florida legislation is ultimately going to be enacted. I do know that there is a great deal of interest in the bills; hearings have been conducted, people from Massachusetts were invited to the hearings in Florida, and groups like AARP are supporting the bill.

I think that that approach, frankly, which is something different than what this subcommittee has had before it in the past, is something that bears more scrutiny and development. Maybe it will get us through the morass of having to go to one extreme or the other, but it would provide relief for seniors who need assignment protection, but it would not do so in areas where physicians might potentially drop out of the program.

[The statement of Mr. Pollack follows:]

MANDATORY ASSIGNMENT

Statement by

Ronald F. Pollack
Executive Director
VILLERS ADVOCACY ASSOCIATES

before the

SUBCOMMITTEE ON HEALTH OF THE
HOUSE COMMITTEE ON WAYS & MEANS

Washington, D.C.

May 7, 1987

Mr. Chairman and members of the committee, thank you for your invitation to testify at this hearing. The issue of protecting Medicare beneficiaries from excess physician billing is particularly important to consider in light of the recent efforts you have undertaken in addressing catastrophic health care expenses.

My comments today will focus on the need for mandatory assignment and highlight some of the activities that the grass roots senior movement has undertaken on behalf of mandatory assignment.

You have demonstrated your awareness that seniors are bearing an extraordinarily heavy burden due to escalating health care costs. I believe that it is critical to review the role physicians and Medicare's reimbursement system play in contributing to this burden. Physicians' ability to accept or reject assignment creates obvious problems of cost and fairness, and continuing to allow them this choice perpetuates inequities for the lower income and chronically ill -- people least able to afford extra cost.

Current Rules

Until the recent implementation of the participating physician program, all physicians were allowed to decide -- bill by bill, patient by patient -- whether to accept direct payment from the government based on Medicare's determination of reasonable charges (referred to as accepting assignment) or to bill patients directly for the amount over Medicare's reasonable charges. The difference between the billed charge and what Medicare allows is referred to as "balance billing" by the provider community and health policy analysts. However what's "balance billing" to some is excess billing to millions of needy seniors.

Physician assignment decisions determine to a significant extent the degree to which beneficiaries are protected by Part B of Medicare. The current Medicare assignment system gives physicians maximum discretion while giving beneficiaries an undependable amount of financial protection. Currently, about 68% of all claims are assigned. However, this figure includes claims for services provided to beneficiaries of both Medicare and Medicaid -- the so-called "crossover claims" -- which are required to be assigned. When crossover claims are excluded, the actual assignment rate is estimated to be in the 48 - 53% range.

Also, assignment rates -- and therefore beneficiary financial protection -- are far from uniform across physician specialties, places of service or types of service. Further, although Medigap policies generally cover Part B deductibles and coinsurance, they usually do not cover the difference between billed and allowed charges on unassigned claims for physicians' services.

Inadequate Coverage

Part B of Medicare, which covers physicians services, is woefully inadequate. Beneficiary liability for Part B services is considerably more than for Part A. Medicare only covers slightly over one half (55%) of physician service expenses of the aged; 42% was paid out-of-pocket. In comparison, Medicare pays for about three-fourths of hospital services. These higher costs to beneficiaries result from the Part B coinsurance and deductibles and excess billing. Before Medicare will pay a dollar towards physician services, a beneficiary must pay a monthly premium that totals $214.80 a year (increased by 86.5% in six years from $115.20 in 1981) and meet an annual deductible of $75 (a 25% jump from 1981). Only then will Medicare pay 80% of its approved charge, not of the actual bill. Doctors are free to charge more, and the majority of doctors (72%) often charge beyond those levels. So beneficiaries are facing an effective coinsurance of about 46% on unassigned claims: the statutorily mandated 20% coinsurance and the 26% by which physician submitted charges are on average reduced by the Medicare Customary, Prevailing and Reasonable system. These unanticipated additional charges by physicians totaled $3.6 billion in 1985 -- approximately $120 per beneficiary.

Participating Physician Program

In an attempt to address beneficiaries' increasing out-of-pocket burdens as a result of excess billing, the Congress initiated a participating physician program. A participating physician is one who voluntarily signs an agreement to accept assignment for all services provided to Medicare patients during the following 12 month period.

The Deficit Reduction Act provisions have had an impact on assignment rate, although that impact appears to have reached its apex and is no longer producing additional favorable results. Indeed, participating physicians fell from 30% in 1985 to 28.4% in 1986. In other words, more than 5% of participating physicians dropped out of the program in FY 86. One can conclude that this voluntary effort is not working.

The intent of the participating physician program was to make it easier for beneficiaries to find a physician who accepts assignment. This was to be facilitated, in part, through published directories of those who have agreed to accept assignment on all of their Medicare claims. Unfortunately, however, we have had reports from senior groups who contacted the carrier for the participating physician list and experienced delays in receiving the list of three to four months or even more. And this was in 1986 after the program had been running a year and one half.

Many have noted the difficulty beneficiaries have in trying to choose a physician on the basis of price, particularly during an illness. Choosing a physician on the basis of accepting assignment is not much easier. Despite the alleged availability of directories, the overwhelming majority of seniors do not know about, and have never received, a directory. This is particularly true for lower income beneficiaries.

For those patients who are being cared for by non-participating physicians, it is a cruel expectation to presume that they will coax their doctors to handle their charges on an assigned basis. Anyone who is sick, particularly if they have a serious health problem, is unlikely to argue with his or her physician about charges. It is not merely a matter of pride, although pride is a factor. One simply does not argue with the physician about his charges, no matter how high, when that physician is viewed as the patient's lifeline. Even where a physician-patient relationship exists over a long period, most

people -- and certainly, most seniors --do not want to place that relationship in jeopardy by quibbling over (even a very consequential) bill.

Grassroots Activity

Mr. Chairman, given these huge doctor bills that seniors have to bear, you can see why in state after state, Medicare assignment has become a priority issue among seniors and their organizations at the grassroots. For most of these organized seniors, it is a concrete step they can take -- often the only step available -- to deal with the soaring cost of health care. This is an example of where an abstract concept hits home. They become aware of the problem every time they visit the doctor, or get seen by a physician in the hospital. They know every time they get a bill.

As a result, grassroots senior organizations have taken on this issue as one that hits their members immediately and visibly right in the pocketbook. It is an issue that gets their members mad. They are mad because they view it simply as an issue of overcharging. They are not familiar with the esoterica of how HCFA computes the Medicare economic index, or how it determines the "customary, prevailing, and reasonable charge" for physician reimbursement. All the seniors know is that Medicare is supposed to cover 80% of their doctors' fees, and that it doesn't. When they write out that check to the doctor after Medicare has paid, they get angry; and grassroots senior organizations don't have to do much digging to uncover that emotion and get people behind a drive to push for more doctors accepting Medicare's assigned rate.

This issue has been addressed in many different ways over the last four or five years. Some groups, including some Gray Panther chapters, initiated much of the work by preparing directories of doctors who took assignment, in the hope that it would encourage some physicians to accept assignment, or at least give senior consumers the information needed to choose doctors who charged no more than Medicare allowed. This work led HCFA to start publishing its own lists as part of the "participating physician" program.

More groups started working on the issue, looking for ways to go beyond the directory approach. They started seeking the cooperation of doctors in accepting assignment, both by having seniors ask their own doctors to do so, and also by approaching the medical societies to seek support. Some groups, such as the Illinois State Council of Senior Citizens, tried to bring the issue to the attention of the media by issuing "Medicare assignment reports," county by county, in the hope that this would put pressure on the doctors and their organizations to accept assignment. Other groups, such as the Dauphin County Council of Senior Citizens, associated with the Pennsylvania Public Interest Campaign, wrote to all the doctors in their area asking them to take assignment, after having failed to get any cooperation from the local medical society. Their use of the media to publicize the results of their mailing both raised public consciousness about the issue, as well as convinced the medical society to sit down with them to discuss the assignment problem.

The Action Alliance of Senior Citizens in Philadelphia combined the patient-to-doctor approach with an organizational approach to some of the specialty trade associations that deal largely with the elderly (like the podiatrists and cardiologists). The United Seniors of Colorado, an affiliate of the National Council of Senior Citizens, tried the carrot and stick approach of holding an awards dinner for those doctors who took assignment 100% of the time. Still other groups tried the harder-edge approach, by issuing a report and having the local paper list the doctors who were and were not accepting assignment.

Another route taken to achieve "voluntary" assignment was through the hospitals. Numerous groups have, over the last several years, worked out agreements with hospitals for special services and discounts (the best examples are in Champaign County [Illinois], Milwaukee, and St. Paul/Minneapolis). The senior groups get benefits for their members (and draw new members because of the benefits), and the hospitals develop a marketing aid. As part of the negotiations leading to these agreements -- and sometimes as follow-up agreements once a working relationship is achieved -- some groups asked commitments from the hospitals to persuade the doctors who practice there to accept assignment for their patients.

These grassroots efforts have helped. Many of the better-run campaigns have increased local assignment rates, usually through pressure or adverse publicity. More seniors are aware of assignment and are more likely to ask their doctors about their billing practices.

However, the gains have been marginal. At the local level, the groups have been unable to move the doctors or their societies to do more on a voluntary basis (which is not surprising given the limited acceptance of the participating physician program). Therefore, the groups have looked to new strategies.

When the Massachusetts senior groups were successful in convincing their state legislature to enact mandatory Medicare assignment legislation, many other senior groups around the country decided to attempt the legislative route to solving their assignment problems. They were frustrated by the failure to persuade doctors at the local level, and optimistic about making their case at the state level. They thought that their state legislatures would be a good forum for their arguments to do something concrete about rising health care costs system-wide, and to keep some precious health care dollars in the seniors' pockets.

Legislation to require doctors to accept assignment has now been introduced in at least 17 states. (These proposals are summarized on the chart appended to this testimony.) As you can see, most of it is modeled on the Massachusetts legislation, which makes accepting assignment a condition of licensure to practice medicine. One interesting exception is in the State of Washington, where the electorate will vote next November on whether a doctor's failure to accept assignment should be a violation of the State's Consumer Protection Act. In some states, the senior groups are reluctantly accepting compromises that may increase the chances of passage, such as exempting medically underserved counties, or that allow doctors to overcharge the well-to-do elderly.

At the time this testimony was prepared, however, the Massachusetts law was still the only mandatory assignment legislation on the books. The senior groups are not finding it easy to counter the inordinate influence of the doctors and their organizations. In part because of the political and financial clout of the doctors, the seniors are finding it difficult to argue against what they perceive as "scare tactics" on the part of the doctors, who say they will stop taking elderly patients or will move out of the state.

It is clear that the doctors' arguments against assignment are beginning to lose their persuasiveness, much as their arguments against Medicare melted away 20 years ago. Clearly, we will see some mandatory assignment legislation passed in the states with better organized senior groups, but in most of the states the doctors will never let the proposals get out of committee.

Mandatory Assignment

If we continue to let the voluntary sign-up process go forward, with some states moving the process along legislatively, we will maintain our patchwork system of coverage for old and disabled people: where health protection is based on where you happen to live, or how personally assertive you are, rather than being based on sound health care policy.

Mr. Chairman, the need is clear. We need you and your colleagues to take us the next step forward and legislate a mandatory Medicare assignment program. And, contrary to what the AMA will tell you -- the same AMA that opposed the creation of Medicare -- we believe that this can be achieved without adversely affecting Medicare beneficiaries.

Any mandatory assignment program would best be accomplished within the context of overall physician payment reform. Combining mandatory assignment with the development of a national fixed-fee schedule would improve access for beneficiaries. A properly designed fee schedule would increase the likelihood that physicians would continue to participate in Medicare. Fixed-fee schedules generally would benefit primary care physicians and would not deter physicians whose business is built on Medicare.

Fee schedules could be based on studies of the time and skill needed to perform the service. Additional factors could be designed to encourage procedures and locations that are relatively cost effective. Over time, such negotiated fee schedules should save money by reducing the rate of increase in reimbursement among physician specialties.

Unfortunately, we recognize that much of the policy debate has taken place without basic information necessary to analyze effects of proposed changes. However, despite physician threats of reduced access for beneficiaries upon implementation of mandatory assignment, we believe that the current physician surplus along with the growing technology available to adjust for geographic differences and Medicare's purchasing power would maintain a high level of physician participation.

In the interim, incremental steps can be taken. As proposed by the Harvard Medicare Reform Project last year, mandatory assignment could be phased in. The Project proposed a three-stage phase-in: 1) assignment should immediately be made mandatory for all in-patient services; 2) put more "teeth" in the participating physician concept so that physicians are required to accept assignment for all Medicare patients they see or not receive any Medicare payment; and 3) assignment eventually be made mandatory for all out-patient charges along with reimbursement reform.

Perhaps as an alternative incremental step, we could adopt the type of approach currently being considered in Florida. Assignment could be made mandatory in all but the places where physicians are in undersupply. By following such an approach, the threat of physicians pulling out of Medicare would be minimized.

We recognize that Congress has tried to improve the situation for beneficiaries through: 1) the participating physician program; 2) the physician fee freeze; and 3) the Maximum Allowable Actual Charge (MAAC) of non-participating physicians. The MAAC is a general cap on charge increases over the Medicare allowed amount to beneficiaries. However, it is clear that for millions of beneficiaries, these steps have not done the job.

We cannot let seniors' abilities to meet their out-of-pocket health care costs be determined by whether they live in the right state or whether they have the right doctor, any more than we can let seniors' health status rest solely on how much money they

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have in their checking accounts. This assignment problem is a nationwide problem, in a national program, and it should not be left to a state-by-state, hit-or-miss resolution.

The issue should be dealt with in a straightforward manner in this national legislative forum, where seniors' needs can be weighed fairly against physicians' needs. Congress should face up to this system-wide problem honestly: give doctors a fair deal, and deal fairly with the older Americans who depend on Medicare to meet most of the health care needs.

7

STATE MANDATORY MEDICARE ASSIGNMENT PROPOSALS

STATE	DESCRIPTION OF PROPOSAL
1. Arkansas	Licensure *
2. California	Licensure
3. Connecticut	Fines physicians charging more than assigned rate to individuals with yearly incomes above $25,000 and couples with yearly incomes above $32,000.
4. Florida	Licensure, with exemptions for medically underserved counties.
5. Illinois	Licensure
6. Iowa	Licensure
7. Maryland	Licensure
8. Massachusetts	Licensure
9. Montana	Licensure
10. New Hampshire	Licensure
11. New Jersey	Licensure
12. New York	Licensure (To be introduced week of May 4, 1987)
13. Ohio	Licensure
14. Oregon	Licensure proposed in committee; changed to compromise that requires doctors to post notice in offices about Medicare assignment and whether doctor accepts assignment
15. Rhode Island	Licensure
16. Vermont	Licensure, with yearly income limits of $25,000 for individuals, and $32,000 for couples
17. Washington	Makes physician's failure to accept assignment violation of state's Consumer Protection Act. Legislature did not act favorably, so will be on the November 1987 ballot as an initiative.

* "Licensure" means that Medicare assignment is required of physicians as a condition of their being licensed to practice medicine in the state.

Source: Prepared by the Villers Advocacy Associates through discussions with the National Health Care Campaign and with state contacts. The chart reflects the status of proposals as of April 30, 1987.

Mr. LEVIN [presiding]. I guess, Dr. Cromwell, you are next. Under our rules I am the one to call on you.

STATEMENT OF JERRY CROMWELL, PH.D., PRESIDENT, HEALTH ECONOMICS RESEARCH, INC., NEEDHAM, MA

Mr. CROMWELL. Thank you.

I am the president and a chief economist of Health Economics Research in Boston, Mass. I would like to thank the committee for inviting me to testify here today on some recently completed research that I have done on the Medicare participation program.

What I would like to do is provide answers to three key questions that are before us. First, why did Congress decide to pass the participation program in 1984? Second, why have physicians chosen to participate in the program, or not? And third, to offer a couple of ways that you might improve or strengthen the program.

First of all, there are two good reasons for having the participation program that discourages balance billing. For an economic market to work properly, patients must have advance knowledge of physician prices. It does no good to open negotiations on fees while under the surgeon's knife.

Second, case-by-case balance billing is really just a transparent form of means testing. It results in physicians enjoying higher incomes than they otherwise would enjoy in a strictly competitive market under a single common price.

Balance billing, which is a euphemism for charging what the market will bear, discourages physicians taking assignment, and ironically results in the Government competing with itself, pitting one beneficiary against another.

Now, we do know that the participation program is working in the sense that assignment rates are up. However, our research shows that only about one-third of physicians signed the original participation agreements. Those who did sign, signed primarily to avoid patient switching, to losing patient cases, or to avoid high collection costs.

The majority did not sign for the promise of higher fees or updates, which suggests that the minor reductions in fees that have already been implemented are not going to really encourage significantly greater participation. Board certified physicians were equally likely to sign the agreement, which was a very positive thing.

The remaining two-thirds who did not sign said they did not do so because they wanted to maintain controls over fees, or they were philosophically opposed to Government interfering with their practice.

Now, let me make a couple of suggestions on how you might strengthen this voluntary program. First of all, I suggest that Congress adopt a participating hospital medical staff agreement. A majority vote of the hospital staff would extend balance billing to all physician in-patient services to participating hospitals. Ambulatory services would be excluded.

This has a couple of advantages. First, it would give beneficiaries the opportunity to avoid any balance billing when choosing their hospital in the first instance. As we all know, patients have no real

control over the specialists that they see in the hospital. Their attending physician does, and he does not bear any of these costs.

The elderly are particularly troubled by unexpected bills from in-patient physicians that they do not remember or they never saw. They cannot make a completely informed economic choice as to which hospital to go to.

A second advantage of this program would be that it would enhance the competition between hospitals and physicians, building on the competition that has been engendered in the current Medicare hospital prospective payment system. I think administrators and physicians alike would appreciate the advantage of protecting their whole in-patient case loads by giving up some balance billing of their colleagues.

A second suggestion I offer is a voluntary all-or-nothing agreement, essentially eliminating the case-by-case option which bothers me so much. Let's give physicians a clear choice: Either you accept all of your patients on assignment or you accept none on assignment. This would also clarify the situation for the elderly, allowing them to make a clearer, more informed choice about the physician they are going to see and how he is going to bill them.

More importantly, the Government would no longer support physicians charging different fees for essentially the same service, which is an illegal pricing practice in the rest of U.S. industry.

We do not let pharmacists charge wealthy beneficiaries more than poor ones, nor do I think Congress wants to delegate that authority to pharmacists.

Mandatory assignment, of course, would be an even more powerful incentive for physicians to participate. There are strong economic arguments that I have developed and published showing that they would accept complete assignment in the majority of cases. This would take full advantage of the elderly's purchasing power, which they cannot do individually.

Surveys and studies that I have done have shown that 80 percent of physicians nationwide would accept mandatory assignment.

In conclusion, I think there has been too much concern over the equity to physicians in setting their fees in ways that are not permitted in other U.S. industries, and not enough concern over the inequities in beneficiaries having to make uninformed choices of their physicians without knowing their total liability beforehand.

Finally, if Congress chooses to decide to means test Medicare, fine, but I do not think it should delegate that responsibility to several hundred thousand physicians around the country with markedly different philosophies towards the rich and the poor.

Thank you.

[The statement of Mr. Cromwell follows:]

THE ORIGINS AND FUTURE OF THE MEDICARE PHYSICIAN PARTICIPATION PROGRAM

By Jerry Cromwell, Ph.D., President, Health Economics Research, Inc.

INTRODUCTION

My name is Jerry Cromwell. I am the President of Health Economics Research, Inc., located in Needham, Massachusetts. Much of my research over the past fifteen years has been devoted to issues of Medicare and Medicaid reimbursement of both hospitals and physicians.

Recently, my colleagues and I at Health Economics Research have made a special study of Medicare's novel Physician Participation Program. I would like to thank the Committee for inviting me to testify on the origins and future of this important new program based on this research.

CONGRESSIONAL MOTIVATION FOR MEDICARE ASSIGNMENT

When the Congress in 1966 established the Part B program that reimburses physicians, it included an option allowing providers to accept the patient's claim "on assignment." This option reflected a mutually advantageous quid pro quo whereby the physician accepts the government's rate as payment in full (except for small deductibles and copays) with no balance billing in order to avoid the costly and time-consuming effort of collecting directly from the beneficiary. The Congress could have required physicians to take all their claims on assignment, but a compromise was struck permitting them complete flexibility in deciding on a case-by-case basis which claims they could refuse assignment and balance bill patients. Indeed, some physicians wanted nothing to do with the government, preferring always to deal directly with their patients. Most, however, continue to this day selectively billing different fees to patients for essentially the same services on a case-by-case basis.

Assignment rates were nearly 60 percent when the program first began but fell steadily through the late 1970's to just 50 percent. Research by myself and others on the growing tendency of physicians to eschew assignment and balance bill the elderly pointed strongly to a fatal flaw in the payment method. By reimbursing up to 80 percent of whatever the physician decided to charge for a particular service, the Federal government had touched off an inflationary spiral fed by physicians raising fees in anticipation of higher government payments.

It also did something more. Private insurers began raising their rates in order to compete with what Medicare was paying. Competition among insurers basing allowable rates on physician stated fees was like pouring gasoline on a fire. The obvious recipient of this insurer competition was the physician while access by Medicare beneficiaries was little improved. In fact, by allowing physicians to selectively refuse assignment, the government effectively pitted wealthier Medicare beneficiaries against poorer ones.

To break the inflationary link between what physicians' said they charged and what Medicare paid, the Congress in 1972 instituted the Medicare Economic Index limiting increases in government payments to the physician's cost of doing business. While effective in controlling the fees that government paid to physicians, it discouraged assignment and resulted in more balance billing.

STRENGTHENING ASSIGNMENT THROUGH VOLUNTARY PHYSICIAN PARTICIPATION

The Congress was therefore faced with a difficult conundrum: If it continued to pay providers whatever they charged for care, runaway inflation was the result; yet when they capped fee inflation, assignment rates fell and beneficiaries were placed in financial jeopardy. One solution to the dilemma was incorporated into the Deficit Reduction Act (DEFRA) of 1984, which imposed a temporary fee freeze on Medicare services and set up a voluntary physician participation agreement. Under this agreement, physicians could voluntarily agree to accept, not just some, but all of their patients on assignment, forgoing any balance billing whatsoever for a year's time. Like the original assignment legislation, various inducements were included to compensate for lost income, e.g.,

- participating physician directories;
- toll-free telephone numbers giving beneficiary information on participating physicians; and
- instant electronic processing of claims.

Also included was a penalty in the form of frozen fees for non-participating physicians which meant no Medicare update the following year.

Since 1984, the Congress (in the Omnibus Budget Reconciliation Act of 1986) has added a few more penalties that reduce payments to non-participants and require physicians to notify the elderly of their potential liability on elective surgery. Prevailing allowable charge levels of non-participants are now set at 96 percent of those of participants. The Congress also moved to protect the unassigned beneficiary by limiting a doctor's actual charges to a 1984 base. The Congress then enhanced beneficiary awareness of participating physicians by sending notices of the program to them on unassigned claims and requiring hospitals to inform patients of physician participation status.

From an economic standpoint, there is an excellent reason why the Congress enacted the physician participation program. For an economic market to work properly, patients must have knowledge of prices and services in advance of their decision. It does no good to open negotiations on fees while one is under the surgeon's knife. But patients are never sure what the physician's total charge will be if balance billing is allowed strictly at the physician's discretion. Hence, they cannot choose their physician based on cost at all, and the power of patients to "vote with their feet," so to speak, is lost. Knowing that a certain family physician or specialist is a participating doctor adds greatly to the patient's knowledge of prices, thereby avoiding any unexpected bills after the operation or office visit.

Moreover, there is an even stronger argument against permitting balance billing at the physician's discretion. By allowing physicians to balance bill and, by their own admission, charging what each patient can afford, the Congress has institutionalized what is considered an illegal pricing practice for hospitals or any other business; namely, charging identical customers different prices for the same product or service. Balance billing case-by-case is a rather transparent form of "means testing," if you will, that allows physicians to enjoy higher incomes at the expense of patients than they would in a strictly competitive market with a single common price. Imagine if bankers charged some borrowers higher interest rates than others because they were better off, defending the policy as their way of making more loans available to the poor. Not only is social welfare reduced by such a practice, it is paternalistic for physicians to decide unilaterally who is worthy of an assigned discount. Until such time as the Congress decides that Medicare ought to be means tested and sets up rules to assure equitable administration, it should not legitimize the practice of charging whatever the market will bear. In this regard Medicare's Physician Participation Agreement is a step in the right direction.

WHY PHYSICIANS PARTICIPATE

Let me next summarize what we have learned about why physicians signed the agreement, and how it could be strengthened. Based on analysis of a large sample of physicians nationwide, my colleagues (Janet Mitchell, Margo Rosenbach, and Sylvia Hurdle) and I have found that the majority who did participate were not attracted by the promise of updated fees after the universal freeze was lifted, but rather to protect against any patient switching, to avoid collecting directly from patients, and in some cases out of a genuine altruism. Nor did we find physicians in areas with rising costs of living more likely to participate in order to receive the promised fee update. This we attribute to the very low inflation rate experienced recently, which naturally dilutes any advantage to fee updates.

The remaining two-thirds of self-employed physicians who declined to forgo all balance billing clearly said they wanted to maintain control over their fees or were philosophically opposed to any government program that interfered with their autonomy. We also uncovered evidence that higher malpractice premiums discouraged participation while the spread of HMOs in an area had the opposite effect--probably out of a need to protect their caseloads. Board-certified physicians did not reject the program as feared, implying that patients of participating physicians are seeing equally qualified doctors. Finally, physicians in the Northeast were more likely to participate when economic factors were held constant, which I attribute to a more receptive attitude towards public programs in general.

There is no question that the Congress' Physician Participation Program is working in the sense that assignment rates are way up. What we do not know is how much the elderly have saved in balance billing or how effective they have been as prudent buyers of physicians' services. We hope to answer these key policy questions soon with on-going support of the Health Care Financing

Administration. Even without precise answers, though, I would like to offer a few suggestions for strengthening the program while maintaining its voluntary character.

RECOMMENDATIONS FOR STRENGTHENING MEDICARE'S PHYSICIAN PARTICIPATION AGREEMENT

First, I strongly recommend that the Congress enact a Participating Hospital Medical Staff Agreement. A majority vote of each hospital's admitting and consulting physicians would extend the ban on balance billing to all inpatient physician services, e.g., surgery, anesthesia, x-rays, and bedside visits. Ambulatory care would be excluded. Patients would then know before being admitted whether they would be liable for higher physician charges, and, armed with such information, they could play a more active role in choosing their hospital based in part on cost. Now, the choice is primarily at their physician's discretion with little consideration of price. In fact, physicians assert over-and-over that they do not want to consider cost when it comes to their patients. Hence, it is crucial that beneficiaries be given the opportunity to decide whether they want to be treated by participating physicians before they enter the hospital. Once admitted, a patient rarely chooses among assistant surgeons, anesthesiologists, consulting cardiologists, and the numerous other specialists with whom they come in contact. Their attending physician makes these choices, although he or she bears none of the extra bills submitted by their colleagues. Not surprisingly, it is the balance billing from specialists the patient does not remember or never saw in the hospital that is most disturbing to the elderly. At least if they knew the hospital permitted balance billing, they would be more psychologically prepared for such shocks. Maybe the next time they might ask their doctor whether a fully participating hospital staff wouldn't be just as good.

Those who defend balance billing often do so on the grounds that it improves access to specialists. This may or may not be true, but the argument is weakest for inpatient care. Once admitted, patients are quite passive in their choice of physicians and certainly lack any foreknowledge of the likelihood of extraordinary charges. With case-by-case assignment by each physician that a patient sees in the hospital, how can the elderly make an informed decision on their next admission? They will not know which physicians they will encounter or who participates and who doesn't. This is why the participation decision must be made jointly by all physicians.

Still another advantage of a Medical Staff Participation Agreement would be its competitive effect on hospital choice. I have recently been travelling around the country interviewing hospital administrators on the competitive effects of Medicare's hospital Prospective Payment System. Lengths of stay and admissions are down almost everywhere, and hospitals are competing for patients through lower prices and new services as never before. For a hospital to be able to say to its potential Medicare patient that all physicians accept assignment all the time in their institution would be a distinct competitive advantage. I am convinced that hospital administrators and medical staffs would appreciate this fact and be encouraged to sign a comprehensive agreement that would benefit most specialists and elderly alike. This is consistent with our research indicating the physician's predominant concern of maintaining their caseloads. It is also consistent with the persuasive arguments hospital administrators have made in medical staff meetings about the need to re-evaluate their use of inpatient services under the Medicare Prospective Payment Program. Patients, of course, could still choose a non-participating hospital in their community, but they would know beforehand that they could be liable for significant balance billing above-and-beyond what Medicare or their supplemental coverage would pay.

Another step the Congress could take to strengthen the current participation agreement would involve dropping entirely the case-by-case option for non-participants. Now, physicians can pick and choose which patients to balance bill. Instead, they should be given a clear, simple decision by the Congress: either sign the agreement and accept Medicare's payment in full for every patient, or begin billing all of your patients directly.

An all-or-nothing choice would serve two useful purposes. First, it would clarify the situation for all elderly patients. Either they would always be protected from any extra bills and the paperwork involved or they would not, depending on which physician they saw. On this basis, they could make a more informed choice, not only of their physician, but how much they would have to spend.

Second, by eliminating case-by-case assignment the government would no longer support the practice of doctors charging different fees for the same service. If the Congress decides to "means test" Medicare, fine, but I do not think it appropriate for it to delegate that right through case-by-case assignment to several hundred thousand physicians with markedly different philosophies toward the rich and poor. Balance billing some patients and not others, while defended as just and equitable in many quarters, is neither when compared to markets for practically all other goods and services. Do we let pharmacists charge wealthier Medicare patients more for the same drug? Would the Congress want to delegate such authority to them in the first place? I hope the answer is no, which is why I am against case-by-case assignment of physicians' services--even on the grounds of equity.

But if physicians were forced into an all-or-none assignment choice, wouldn't that work to the detriment of the elderly? Might physicians who refuse to participate burden poorer patients with more paperwork and extra billing? Might assignment rates actually fall? Research that my colleagues and I conducted in the 1970's on the all-or-nothing choice suggested that it would, but the world is different today ten years later. Physicians were scarcer then; now we have a glut of doctors. Today they are very sensitive to maintaining caseloads, and it is unlikely they would risk losing patients, even poorer ones, by refusing to participate. Medicare still pays a competitive amount to most physicians for these cases. In my opinion, I do not believe physician participation or assignment rates would fall under a voluntary all-or-nothing program and would likely rise in today's competitive world as the Congress enhances the beneficiary's market power.

VOLUNTARY ALL-OR-NOTHING VERSUS MANDATORY ASSIGNMENT

In closing I would like to make a fundamental distinction between the voluntary all-or-nothing participation agreement that I have just recommended and mandatory assignment. If the Congress enacted a voluntary all-or-nothing assignment option, physicians could choose not to participate at all and still treat Medicare eligibles who could then collect directly from the government. In so doing, the net out-of-pocket portion of the physician's bill remains low in general, and patients are not strongly discouraged from seeing a non-participating physician. Under mandatory assignment, the beneficiary cannot collect anything directly from Medicare if the physician refuses assignment. Physicians could continue to treat the unassigned elderly, but 100 percent of their bills would be paid for out-of-pocket. In more recent research of ours on mandatory assignment, physicians have overwhelmingly reported (over 80 percent) that they would take all patients on assignment in such a program. Mandatory assignment, therefore, is predicted to have a much stronger positive effect on assignment rates than any form of voluntary participation.

However, if voluntary all-or-nothing assignment is the only acceptable political compromise at this time, I still recommend that the Congress adopt it--particularly if the law also includes a hospital medical staff agreement as well. I base this recommendation on both efficiency and equity considerations. For patients to make an informed decision on the value of physicians' services, they must have a better understanding of their total liability before selecting a physician and undertaking a course of care. Case-by-case assignment only adds to their uncertainty and, hence, should be strongly discouraged. Secondly, until such time as the United States Congress decides that Medicare ought to be "means tested," it should constrain physicians from implicitly doing so through case-by-case balance billing.

Chairman STARK. Thank you, Mr. Cromwell.
Mr. Newsom?

STATEMENT OF WILLIAM R. NEWSOM, EXECUTIVE VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD OF KENTUCKY, INC., ACCOMPANIED BY FRANK E. BROADUS, JR., VICE PRESIDENT OF GOVERNMENT PROGRAMS, ON BEHALF OF BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. NEWSOM. Thank you, Mr. Chairman. I have with me Frank Broadus who operates our day to day operations for Government programs, including the Medicare program.

We are pleased to appear here today on behalf of the Blue Cross and Blue Shield Association, which is the national coordinating organization for all of the Blue Cross and Blue Shield plans. These plans have been designing and administering various payment arrangements with physicians and hospitals and other providers for well over 50 years now.

The association and plans also serve as Medicare intermediaries and carriers responsible for most of the day to day administration of this important Medicare program. Blue Cross and Blue Shield of Kentucky is the largest health insurer in the State and provides benefits to more than 1-million subscribers.

The plan is also the Medicare intermediary and the part B carrier for beneficiaries in the State. As the part B carrier, we provide service to approximately 500,000 Medicare beneficiaries and more than 4,500 physicians in active medical practice in the Commonwealth of Kentucky.

We know from experience in the private market that participating physician programs are very important in protecting patients from unexpected and excessive financial liabilities. We would encourage this subcommittee to make all the efforts possible to retain and increase the viability of the participating physician program under Medicare.

We would urge that as you consider proposals to increase physician participation you recognize the important protection afforded beneficiaries on individual claims for which physicians do accept assignment.

It is critical that efforts to improve the participation rate, which is now about 31 percent, not have a negative effect on the overall claims assignment rate, which is now about 71 percent, and of course, this is the highest in our history.

The Blue Cross and Blue Shield association opposes mandatory assignment or participation. We believe the best approach is to encourage physicians to participate voluntary by offering various incentives to the physicians.

In considering what could be done or what offers could be made, it is important to understand some of the factors that now act to discourage participation by physicians. First, we believe that the unpredictability of Medicare policy since the physician payment and fee freeze were implemented in 1984, no doubt, has made many physicians skeptical of entering into a participation arrangement.

Second, the level of Medicare payment allowances can discourage participation. A third factor is less-than-optimal service to physi-

cians and beneficiaries under the Medicare program. The payment delays that have occurred under Medicare since 1985 and the confusing signals concerning Medicare claims payment policy no doubt discourage some physicians from seeking payment from the Government, as opposed to direct payment from beneficiaries.

The minimal effort and funding that is directed toward provider education and inadequate funding of other Medicare carrier activities, such as handling inquiries and appeals, also affect service levels under Medicare. Participation in Blue Cross and Blue Shield private market programs are considerably higher than they are in the Medicare program.

For example, 27 percent of Kentucky's physicians participate in Medicare, and in comparison, under private Blue Shield business, the rate is 81 percent. In Kentucky, we believe the two most significant reasons for this difference are the level of payment and the promotion of physician participation through active professional relations programs. Medicare pays physicians about 28 percent less than Blue Cross and Blue Shield of Kentucky pays for like services.

Additionally, physicians as participating Blue Shield physicians know that payment changes will not be made during the program year for which a fee screen is applied. Also, unlike the current Medicare program which has an enrollment period for 30 days once a year, nonparticipating physicians are offered the opportunity to participate with the Blue Shield physician program at any time during the year. This effectively creates an open enrollment for participation. Finally, under exceptional circumstances when we are unable to agree upon fees, we take these cases through a formal appeals process to determine reasonableness. There are ways and means to discuss these things beyond an arbitrary decision being made.

We believe there are number of things that HCFA and the carriers can do under current law to maintain and enhance physician participation. Our written statement lists numerous administrative initiatives we believe should be considered by HCFA and carriers. Many of these initiative could be pursued under the authority of current law, which requires carriers beginning in fiscal year 1988 to implement programs to recruit and maintain participating physicians.

Adequate funding for part B carrier responsibilities is critical. For example, at the administration's budget requests for fiscal year 1988, we believe that Medicare contractors will have a very difficult time meeting the prompt payment standards in current law, which require payment of most participating physician claims within 19 days, and most other claims within 26 days.

Legislatively, we recommend a clarification to current law so that carrier performance in promoting participation is measured based upon the number or proportion of claims submitted by participating physicians, rather than on the proportion of total physicians who participate. We also recommend that all part B policy changes, whether legislative or administrative, be given effective dates that correspond to the physician's participation contract year, normally beginning on January 1.

Perhaps in the longer term a fee schedule would simplify the program and make it easier for physicians and beneficiaries to un-

derstand. This could attract higher levels of participation and assignment, provided, of course, that the payment levels are reasonable. We look forward to the results of the Harvard study of a resource base relative value scale and the recommendations of the physician payment review commission in this area.

We believe there are a number of activities that could be pursued under current law to educate beneficiaries about the physician participation concept, and our written statement contains five specific recommendations along these lines.

We would like to raise two related issues. First, we would suggest that Congress consider establishing incentives for part B suppliers to participate in Medicare. And second, we would like to bring to your attention the increasing number of claims denials by part B carriers for unassigned lab tests performed by physicians.

Under the Reconciliation Act of 1985 these unassigned lab tests are noncovered and a beneficiary must pay them in full. These denials can place an unexpected and often very significant burden on beneficiaries.

The Congress may wish to consider requiring advanced disclosure to beneficiaries of a physician's decision not to accept assignment on tests so that the beneficiaries understand that he or she will be responsible for the full costs of those tests.

In conclusion, the Blue Cross and Blue Shield Association believes strongly that the physician participation and acceptance of assignment on claims are the keys to assuring adequate beneficiary protection under Medicare.

We support efforts to provide greater incentives for physicians to participate and accept assignment and to improve the overall administration of the program, and of course, we would be pleased to work with the subcommittee on any specific proposal you might wish to consider in this area.

Thank, you, sir.

[The statement of Mr. Newsom follows:]

TESTIMONY OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION ON PHYSICIAN PARTICIPATION IN MEDICARE, BY WILLIAM R. NEWSOM, EXECUTIVE VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD OF KENTUCKY, INC.

Mr. Chairman and members of the subcommittee, I am William R. Newsom, Executive Vice President of Blue Cross and Blue Shield of Kentucky, Inc. Accompanying me today is Mr. Frank F. Broadus, Jr., Vice President of Government Programs. We are pleased to be here today to comment on maintaining and improving physician participation in the Medicare program.

I am appearing today on behalf of the Blue Cross and Blue Shield Association, the national coordinating organization for all the Blue Cross and Blue Shield Plans. These Plans have been managing health care benefits and designing and administering various payment arrangements with physicians, hospitals, and other providers of health care for over 50 years. Today, in the private health insurance market Blue Cross and Blue Shield Plans underwrite and administer health care benefit plans for 77 million subscribers.

Under contracts with the Health Care Financing Administration, the Association and Plans serve as Medicare fiscal intermediaries and carriers responsible for most of the day to day administration of this important program. Nationally, Blue Cross and Blue Shield Plans are responsible for handling about 88 percent of Medicare Part A bills and two-thirds of all Part B claims.

Blue Cross and Blue Shield of Kentucky is the largest health insurer in the state, providing health benefits to more than one million subscribers. The Plan is also the fiscal intermediary and Part B carrier for beneficiaries in the state. As the Part B carrier, we provide service to approximately 500,000 Medicare beneficiaries and more than 4,500 physicians in active medical practice in the Commonwealth of Kentucky.

Blue Cross and Blue Shield Association Position

We know from experience in the private market that participating physician programs offer the best promise for simultaneously controlling physician payments and protecting patients from unexpected and excessive financial liabilities. The vast majority of Blue Cross and Blue Shield Plans have programs under which participating physicians agree to accept Plan payments as full reimbursement for services delivered to their subscribers. Important to the success of these programs is a reasonable level of payment.

We encourage the subcommittee to make all efforts to retain and increase the viability of the participating physician program under Medicare. We also would urge that as you consider proposals to increase physician participation you recognize the important protection afforded beneficiaries on individual claims for which physicians accept assignment even though they may not participate. It is critical that efforts to improve the participation rate, which is now about 31 percent, not have a negative effect on the overall claims assignment rate, which is now about 71 percent.

The Blue Cross and Blue Shield Association opposes mandatory assignment or participation. We believe the best approach is to encourage physicians to participate voluntarily by offering various incentives. In considering what efforts could be made, it is important to understand the factors that now act to discourage participation. In doing so, however, we should not lose sight of the fact that Medicare participation did increase in 1987, and that the assignment rate is now the highest in history. The recommendations that we will make later in the testimony are intended to provide greater incentives for physicians to seek payment from the Medicare program rather than billing beneficiaries directly.

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Factors that Discourage Medicare Physician Participation

Based on our experience, we believe there are a number of factors that discourage participation. Unfortunately, we are not aware of any studies that identify precisely what influence each of these factors has on the participation decision.

First, we believe that physician apprehension over Medicare policy changes does discourage many from entering into the one year participation contract. Frequently, policy or administrative changes that have significant effects on physician reimbursement are implemented after physicians have entered into the contract. For example, a mandatory delay in the payment of electronically submitted claims, an administrative change which might be implemented later in this fiscal year, could have significant effects on an individual provider's cash flow. Moreover, the unpredictability of Medicare payment policies since the physician payment and fee freeze were implemented in 1984 has no doubt made many physicians skeptical of entering into a participation contract.

Another factor that can discourage participation is the level of Medicare payment allowances. For many procedures Medicare payment levels are significantly below those paid by private payers. This, of course, is not true in all cases and for all physicians. Conversely, we recognize that there are certain procedures for which Medicare payments are overpriced given changes in technology and other factors that have reduced the cost of performing the procedure. In this regard, we have supported implementation of the "inherent reasonableness" concept, with appropriate safeguards and guidelines.

A third factor is less than optimal service to physicians and beneficiaries under the Medicare program. The payment delays that have occurred under Medicare since 1985 and the confusing and often conflicting signals concerning Medicare claims payment policy no doubt discouraged some physicians from seeking payment from the government as opposed to direct payment from beneficiaries. While the prompt payment provision of last year's reconciliation bill did establish standards for Medicare payment timeliness, there has been a lot of confusion over the implementation of these changes. In particular, there has been, and continues to be, questions about whether floors can and should be established below these payment timeliness standards. These floors would require a minimum period of time to elapse before a claim could be paid. In our private business, we do not pursue policies of intentionally delaying claims payments.

Contributing to the less than optimum service level of the Medicare program is the minimal effort and funding that is directed towards provider education. In addition, inadequate funding of other Medicare carrier activities also contributes to a less than optimum service level under Medicare. For example, the carrier administrative expenditures for handling physician and beneficiary inquiries and appeals are limited by the "unit cost caps" used to set contractor claims processing budgets. In its report last year, the GAO found that these unit cost caps were inconsistent with the Congressional intent in enacting changes in the Medicare contracting provision in 1984.

Many of the factors that discourage physician participation under Medicare do not apply in our relationships with physicians in the private market. Thus, participation in Blue Cross and Blue Shield private market programs is considerably higher than in Medicare. For example, 27 percent of Kentucky's physicians are enrolled in the Medicare participation program. In comparison, our private Blue Cross and Blue Shield of Kentucky physician participation rate is 81 percent.

In Kentucky we believe the two most significant reasons for the difference between Medicare and Blue Cross and Blue Shield's physician participation percentages are the level of payment and the promotion of physician participation through an active Professional Relations Program. With respect to level of payment, Medicare reimburses physicians approximately 28 percent less than Blue Cross and Blue Shield of Kentucky for like services. Additionally, physicians know:

-- that payment changes will not be made in the program during the one year period for which fees are established.

-- unlike the current Medicare program that has an enrollment period for 30 days once a year, non-participating physicians can contract to participate with our Blue Cross and Blue Shield physician program at any time during the year, effectively creating a continuous open enrollment.

-- and, under exceptional circumstances, fees are subject to a formal appeals process to determine reasonableness.

Since its inception in 1984, the Medicare participating program has had numerous changes that have resulted in considerable confusion. Conversely, Blue Cross and Blue Shield of Kentucky has had a participating program in the state for almost twenty years and during this time period it has only changed once. We also have an ongoing Professional Relations Program for our private business, which is described later in our testimony.

<u>What Can Be Done to Maintain and Enhance Physician Participation?</u>

We believe there are a number of things that HCFA and the carriers can do under current law to maintain and enhance physician participation. It is, however, difficult to project what effect these activities may have given that many of the factors that influence a physician's decision to participate are beyond the control of HCFA and the carriers. It is also important to distinguish between those activities directed towards physicians and those activities directed to educating beneficiaries about the physician participation program.

<u>Initiatives Targeted to Physicians</u>

We believe that the following initiatives should be considered by HCFA and carriers:

1. Fund the installation and maintenance of toll-free lines at all carrier sites to handle inquiries from participating physicians.

2. Provide Medicare claim forms to participating physicians free of charge.

3. Send the Maximum Allowable Average Charge (MAAC) information along with the "Dear Doctor" letter that solicits physician participation. While this information may or may not encourage participation in a particular case, it would go a long way in demonstrating the government's commitment to providing physicians with the information needed to make well-informed decisions. Practical constraints prevented this from occurring last December, but this goal is attainable for 1987 if this year's reconciliation act is enacted before October.

4. Increase the lead time for carriers between the announcement of Part B payment policies and the physician participation solicitation period. Adequate information and lead time are essential any time changes in the Part B program are planned. This is particularly critical when seeking physician participation in the program. Also, we believe efforts should be made to encourage carrier

innovation in developing informational and promotional materials to be sent to physicians.

5. Consider doubling the one month physician sign-up period if this would not conflict with the timing of the enactment of budget reconciliation legislation.

6. Develop publications, films, videotapes, etc. targeted to the physician community.

7. Consider offering a larger and more appropriate "PAR Physician" plaque for display in physicians' offices to better inform beneficiaries as to a physician's participation.

8. Clarify and stabilize Medicare claims payment timeliness policy to assure prompt payment.

9. Enhance carrier professional relations staffs. In Kentucky, our Professional Relations Program for private business includes personal visits to physicians on a regularly scheduled basis to provide education and promote participation, annual workshops for physicians and their office staff, a monthly newsletter to all physicians, and concentrated campaigns to increase participation in targeted areas where physician participation is low. Current Part B carrier budgets do not allow for this level of activity.

10. Use the "inherent reasonableness" authority, where appropriate, to increase payment levels for any underpriced procedures.

11. Assure adequate funding for Part B carrier responsibilities. For example, at the Administration's budget request for FY 1988, we believe Medicare contractors will not be able to meet the prompt payment standards in current law which require payment of most participating physician claims within 19 days and most other claims within 26 days.

Many of these activities could be pursued under the authority of current law which requires carriers, beginning in FY 1988, to implement programs to recruit and maintain participating physicians. Under this authority, carrier performance will be evaluated and financial bonuses not to exceed in the aggregate one percent of the total Part B contractor budget will be provided to successful carriers.

In this area, we would suggest a legislative clarification to current law so that carrier performance is measured based on the number or proportion of <u>claims</u> submitted by participating physicians, rather than on the proportion of total physicians who participate. This change would focus carrier efforts on attracting those physicians who routinely treat Medicare patients. We also would suggest that carrier specific programs to increase physician participation should not be implemented if they have an adverse effect on the assignment rate. Finally, because there are factors beyond the carrier's control that could affect physician participation, such as the allowable increase in Medicare fee screens, we would urge that carriers not be penalized in the performance evaluation program for failure to increase participation.

We also believe there are legislative changes that should be considered that could enhance physician participation. Overall, we recommend greater stability and predictability in the Medicare Part B program. One specific legislative approach that should would improve improve program stability and predictability would be to give all Part B policy changes

effective dates that would correspond to the physician participation contract year, which begins on January 1. Congress could also consider the further step of prohibiting the issuance of significant Part B program regulations and instructions during the participating physician contract year.

In the longer term, a fee schedule should simplify the program and make it easier for physicians and beneficiaries to understand. A well understood and more predictable payment program could attract higher levels of participation and assignment, provided that the payment levels are reasonable. We look forward to the results of the Harvard study of a resource base relative value scale and the recommendations of PhysPRC in this area.

Another legislative option that has been discussed relates to "piggyback" billing which refers to the practice of determining the liability under a Medicare supplemental policy based on information about Medicare claims provided by the Part B carrier. Piggyback billing arrangements are presently in force in many areas and are available to all physicians and beneficiaries in these areas, not just to those physicians who participate. Under the current rules, a Medigap carrier voluntarily can enter into an agreement with the Medicare Part B carrier under which the Medigap insurer reimburses the Part B carrier for the cost of the Medicare data necessary to process the Medigap claim. Where these arrangements are in force, beneficiaries or providers need only file one claim to obtain reimbursement from the Medicare program and the Medigap insurer. This relieves the provider and beneficiary of the administrative burden of submitting more than one claim.

We believe that the most feasible and reasonable approach to utilizing piggyback billing as an incentive for physician participation would be to require the Medicare carrier to send to the Medigap insurer identified on the claim form the necessary documentation to enable the Medigap insurer to determine its liability. This proposal would, however, increase Medicare administrative costs. We would be pleased to work with the subcommittee and the Health Care Financing Administration to explore this proposal and other ways to expand the use of the "piggyback" billing arrangement.

Initiatives Targeted to Beneficiaries

We believe there are a number of activities that could be pursued under current law to educate beneficiaries about the physician participation concept:

First, we would suggest that the information booklet which describes the Medicare program, "Your Medicare Handbook," be made available in bulk quantities to all Medicare Part B carriers to distribute to beneficiaries upon request.

Second, Part B carriers should be funded to communicate routinely, in writing and in person, with local senior citizen groups. This communication effort could include media campaigns as well as newsletters to be sent to beneficiaries.

Third, Part B carriers could consider developing programs to train volunteers and hospital staff and develop information packets to educate beneficiaries upon hospital admission about the participating physician program and the participation status of hospital-based physicians.

Fourth, Part B carriers could consider, where appropriate, developing and installing optional pre-recorded messages available on carrier toll-free beneficiary inquiry lines to explain the participating physician program.

Finally, in addition to the carrier toll-free lines for beneficiaries which now exist, we would suggest the establishment of a national HHS toll-free line either to locate participating physicians for beneficiaries or to route their calls to the appropriate Part B carrier.

Related Issues

In addition to the suggestions outlined above to maintain and enhance physician participation and to improve beneficiary understanding of the program, we would also suggest that the Congress consider establishing incentives for Part B suppliers to participate in Medicare. Currently the four percent differential in prevailing charge screens applies only to physicians and not to Part B suppliers under Medicare.

We also would like to bring to your attention the increasing number of claims denials by Part B carriers for unassigned lab tests performed by physicians. Under Section 9303 of the Consolidated Omnibus Budget Reconciliation Act of 1985, these unassigned lab tests are non-covered and the beneficiary must pay for them in full. These denials can place an unexpected, and often significant, burden on beneficiaries. The Congress may wish to consider requiring advance disclosure to beneficiaries of a physician's decision not to accept assignment on these tests so that the beneficiary understands that he or she will be responsible for full payment.

Conclusion

In conclusion, the Blue Cross and Blue Shield Association believes strongly that physician participation and acceptance of assignment on claims are the keys to assuring adequate beneficiary protection under Medicare. We support efforts to provide greater incentives for physicians to participate and accept assignment and to improve the overall administration of the program.

We would be pleased to work with the subcommittee on any specific proposals you may consider in this area.

Thank you.

826:5/5/87

Chairman STARK. Thank you very much.

Dr. Cromwell, physicians often tell us that it is none of our business about extra billing because it does not affect the Federal budget so why do we not just keep our noses out of their business. Does extra billing affect our ability to control costs, or could the participating physician program help reduce the cost for the elderly? Is there some indirect effect that we get out of that?

Mr. CROMWELL. Well, balance billing obviously relates primarily to the incidence of the burden of payment. In balance billing, the incidence falls primarily on the beneficiary and not the Federal Government in the first instance.

I am concerned that there is a belief that balance billing is only being done on the wealthy beneficiary. A lot of the balance billing, it is my guess, is being done to the beneficiary with supplemental insurance, and having that supplemental insurance, while it does not cover the balance bill, it enables that medium-income beneficiary to pay extra balance billing. So it is not necessarily only the wealthy or the Boeing president who are being billed. It is billed systematically to those that already have more insurance, reinforcing the moral hazard of insurance.

In terms of your ability to control costs, to my mind unless you control the entire bill, which includes both what the Federal Government as well as what the beneficiary pays, you are really not going to get complete control over health care costs.

Chairman STARK. Let me ask. Mr. Newsom, is it conceivable that if you take two or three patients, Medicare beneficiaries, with about the same income level, that they could have different supplemental or different paying? Under Blue Cross they might get more for a gall bladder removal, and under Aetna they might get less, and the doctor knows this, so that if the same group of patients were there, they could bill one higher just because they are paying for a more generous insurance program. Is that common?

Mr. NEWSOM. No. Mr. Chairman, normally what happens in what is referred to as medigap coverage is that most reputable organizations will pick up the 20 percent not covered by Medicare.

Chairman STARK. Yes. But then it would seem to me that if you had medigap for the 20 percent. Let's say there is a $1,000 approved Medicare payment under participation. You pick up $200 of that and Medicare pays $800. But suppose you have a medigap policy and someone else does not. I am the doc, I say, well, you both can pay the $200, so I will bill you $1,200 but I will only charge the other guy $1,000.

Is that what you are suggesting, Dr. Cromwell?

Mr. CROMWELL. Yes. I think that is exactly what is happening. The existence of the medigap insurance encourages balance billing. I am not necessarily against the medigap insurance. I am against balance billing on strong economic grounds.

Chairman STARK. Well, doctors argue for some kind of assignment limited to low income people, still a means test to me. It is all the same sort of difference.

I guess there are some subtle differences in that, but taking away the demeaning nature, the fact is, that you might encourage two levels of practice. If there could be some way that a person

could be an A, B, or C payer and nobody would know it, what is wrong with that kind of means testing?

Mr. POLLACK. Mr. Chairman, if I may answer first with a little tongue in cheek. In Connecticut, the physicians actually had a proposal along those lines. They wanted to means test what would be mandatory assignment or not.

Chairman STARK. How did they go about that? Can you give us a little bit of an outline?

Mr. POLLACK. Yes. In Connecticut, the proposal currently pending before the State legislature essentially uses the same income criteria as the Social Security threshold for taxation of Social Security benefits, $25,000 for an individual, $32,000 for a couple.

Chairman STARK. But what happens there?

Mr. POLLACK. Well, it is mandatory assignment would be applicable for those under and it would not be applicable for those over.

Chairman STARK. And the docs in Connecticut would buy that?

Mr. POLLACK. Well, this is the proposal currently pending before the Connecticut Legislature, and those doctors had suggested that kind of approach.

The senior citizens group in Connecticut actually turned that on its head and said, well, we are in favor of means testing but why do we not means test doctors? We will have a mandatory assignment program and we will have an exception program for those doctors whose income falls below $105,000. We will give them an exception with respect to whether they are required to accept mandatory assignment, but we will impose it for those over $105,000.

I said that truly with tongue in cheek, but that is actually what happened in Connecticut.

Chairman STARK. Okay. Was there a general agreement among the physicians' groups in Connecticut that they would accept something like that kind of a cliff? Say a $25,000 income and below we will take mandatory assignment and above we will not?

Mr. POLLACK. I do not know whether the physician proposal used the exact same figures that are currently pending before the Connecticut Legislature, but they did agree to that approach.

Chairman STARK. But it was not something like $3,000?

Mr. POLLACK. No. It was not, but they did have the same approach, although I think the threshold dollar figures were somewhat different. And they did agree to that, just like apparently they did in the State of Washington. I have heard that in other States as well.

Having said that, however, I think there is a different question about means testing when it comes to mandatory assignment than when it arises for the kinds of questions you are having to grapple with now in the context of the catastrophic bill.

There you are trying to deal with limited Federal, or in some instances, State dollars, and you are trying to preserve the fisc and you are trying to figure out how to target limited dollars effectively.

This is not the same thing. In the mandatory assignment controversy, you are not trying to ration any kind of governmental funds. Rather, we are talking about the potentiality for a two-class system in the physician's office. While the approach of means testing makes some sense when you are targeting small amounts of Feder-

al or State dollars, I am not sure it does with respect to mandatory assignment.

But I will say to you that physicians in different places around the country in some States have said that they would accept mandatory assignment on a means testing basis.

Chairman STARK. Anybody else?

Mr. CROMWELL. Well, 80 percent of them have said they will accept it on any basis.

Chairman STARK. Say that again.

Mr. CROMWELL. Eighty percent of them have said they will accept it on any basis, mandatory assignment.

Chairman STARK. They will not accept it?

Mr. CROMWELL. They will.

Chairman STARK. They will?

Mr. CROMWELL. They will accept it. When asked whether they would agree to sign a mandatory assignment agreement or have their beneficiaries uninsured, they said yes, "I would sign that agreement irrespective of any means testing." So there is no question that the Government has significant economic power in making physicians decide.

Chairman STARK. Well, the only thing I am getting at is that I could be persuaded, I think, you could take the Social Security tax level and that probably gets us 70 percent of the Medicare beneficiaries——

Mr. POLLACK. It is actually more than that.

Chairman STARK. Is it higher? Probably 80?

Mr. POLLACK. I think it is closer to 90 percent.

Chairman STARK. Well, you know, you suddenly hit my level of compromise. If I can take 90 percent, 27 or 26 million of the 31 million beneficiaries, and they go in under participation or assignment, I could rationalize that the very high income groups probably also have some better economic ability to pay and negotiate later, and we are taking care, obviously, the poorest of the poor.

It may not be a perfect world, but it would get us a lot closer.

Mr. POLLACK. Mr. Chairman, when you stepped out you had raised the question with the previous panel about why is it that the senior groups are divided on this question. You mentioned, for example, AARP and the Roosevelt group being opposed to mandatory assignment and other groups, like the National Council of Senior Citizens, that have been supporting mandatory assignment.

In our discussions with AARP to see whether there could be some coalescing of interests, there was one common ground that I thought existed, and that is comparable to the approach that is being looked at in the State of Florida that you see on page 15 of my testimony.

The largest concern expressed to us by AARP was that physicians were going to drop out of the program if there was mandatory assignment.

Chairman STARK. What is the Florida approach, just quickly?

Mr. POLLACK. The Florida approach essentially establishes mandatory assignment and then exempts medically underserved areas, so that in those areas where the supply and demand is out of balance—and it is normally in a rural area—and there is a greater

likelihood that physicians are going to drop out of the program, it is in those areas where you would exempt mandatory assignment.

Now, AARP, as best I understand it, is supporting that Florida legislation.

Chairman STARK. What about Massachusetts? There is another route you can follow.

Mr. POLLACK. In Massachusetts they supported the legislation, but they have not supported that approach in other places. The reason they supported it in Massachusetts was because you do not have that underserved configuration as you do in many of the rural areas.

But in Florida, where you have some underserved areas, they were willing to abide by that approach, and I think if we could look at that and try to develop that in a somewhat more sophisticated manner, I think we have got a handle by which we can develop some unison on this issue.

Chairman STARK. You have just touched on the access issue, and I would recognize Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

Mr. Newsom, I would like to inquire further about the procedure that is used in your State when there is a disagreement with physicians about the appropriate fee level. I would like to see if it is possible to reach a point at which rates could be negotiated. Yet your organization negotiates a mandatory rate.

That is why I inquire about this. It would seem to me that if some day we develop a relative value scale system, that you end up, conceptionally having to negotiate an hourly rate and then plugging that into the system.

How do you do it in Kentucky?

Mr. NEWSOM. Well, essentially, the process begins whenever a physician or a specialty group of physicians and Blue Shield come to a level of disagreement on what is an appropriate or fair fee for a particular procedure. If we cannot agree upon that, of course, first of all, we go out and check with our sister Blue Shield plans and say, well, okay, are we doing some things wrong here in our payment level that is causing this kind of a problem.

We check with other areas of the country about what physicians in other areas are charging for that kind of procedure, and then we set down and try to work out a compromise. If we cannot, we then go to a peer review structure where we get professional input from physicians as to the difficulties of the services or the procedures. Oftentimes they have debates among themselves, you know. We have found our physicians, once they really look at these issues very carefully, they come down on one side or the other. They do not necessarily always agree, but we do come to a good compromise. There are appeal procedures beyond the county, on into the regional and into the state levels.

Mr. GRADISON. Is it in effect a binding arbitration? If, after all of the reviews all the way through the State level, you are still in a disagreement, what happens? Do physicians just not participate in your program?

Mr. NEWSOM. So far we have mutually agreed on this. Obviously, it does not require us legally to do so, but we have found it has

worked well. The physicians are not always happy, we are not always happy, but we do find reasonable compromises.

Mr. GRADISON. Thank you very much. Thank you for your testimony.

Chairman STARK. Mr. Daub?

Mr. DAUB. Thank you, Mr. Chairman.

Do you favor mandatory assignment, Blue Cross and Blue Shield?

Mr. NEWSOM. No, sir, we do not.

Mr. DAUB. So you are opposed to mandatory assignment. Why are you not in favor of mandatory assignment, so that the record is clear?

Mr. NEWSOM. We feel that it has dangerous elements to it, that it could in many areas of the country, we believe, limit access of Medicare patients to physicians, either at the primary level or at the specialty level.

We believe that the voluntary programs can work. We think there are some things we have not done we should do, and we would like to give that a good solid chance rather than going out and having the Federal Government mandate what everybody is going to do.

Mr. DAUB. Well, the social reformers do like to have a system that has the mandatory element on the one side and then turn right around. A good example of that might be just this afternoon at 3 o'clock in our closed committee markup of the catastrophic bill, to appreciate the fact that we will end up essentially social——

Chairman STARK. You old social reformer, you. [Laughter.]

Mr. DAUB. Well, I could plead guilty on several counts, including part C, Mr. Chairman. I will just admit it.

But the fact is that the system is almost going to be mandatory when you get done with it. Part A is going to be just about totally taken care of and part B is going to be almost taken care of when we finish. That is from the patient's point of view. Why not just make it all mandatory? I mean, we are almost there already.

Mr. NEWSOM. Not at this time, at least on the B side, I do not believe we are.

Mr. DAUB. Your catastrophic threshold will be under $2,000. You do not have to save any money. I might as well not even buy a Blue Cross or Blue Shield Medigap policy anymore. I am not going to really be out-of-pocket very much.

Mr. NEWSOM. I am sorry. I was speaking once again of the mandatory assignment.

Mr. DAUB. Well, I am too, but I am just saying, why fight it any more? Why not just——

Mr. NEWSOM. Do you mean just go ahead and turn it over to socialized medicine?

Mr. DAUB. Is that not where we are headed? Are we not almost there?

Mr. NEWSOM. I surely hope not.

Chairman STARK. If the gentleman would yield, on part B, even with catastrophic there is still extra billing. If somebody extra bills there could be $50,000 out-of-pocket in extra billing fees.

Mr. DAUB. Well, the difference between billed versus what is approved versus what is paid.

Chairman STARK. We are talking about extra billing.

Mr. DAUB. I am just trying to get him to refine his ideas, Mr. Chairman, on mandatory assignment.

Mr. POLLACK. Mr. Chairman?

Mr. DAUB. I will be with you in a minute because I have read your testimony. [Laughter.]

Do you have any other reasons why you are against mandatory assignment besides what you have said? You are saying you are worried about services but——

Mr. NEWSOM. I am also worried about, as a system, the level and expertise and a deterioration of the system.

Mr. DAUB. Okay, thank you.

Now, Mr. Cromwell, very quickly, you said in your testimony that we do not allow prices and charging like this in other industries in our society, or in other sectors in our society.

What did you mean? Can you give me some examples of what you meant by that?

Mr. CROMWELL. Well, for drugs.

Mr. DAUB. Is it what we are doing here needs to be tailed up and more Government administered because we evidently do that in other sectors?

Mr. CROMWELL. It is not Government administered. I mean, there are standard FTC laws for pricing automobiles and drugs and oranges and every other thing we buy in this country. Consumers are simply not charged different prices for the same service, and the Federal Government has extensive laws not——

Mr. DAUB. Wait, what is this now? Automobiles?

Mr. CROMWELL. Try automobiles.

Mr. DAUB. What?

Mr. CROMWELL. Automobiles.

Mr. DAUB. Financing or what?

Mr. CROMWELL. I am talking about the purchase price of the car.

Chairman STARK. Sure. Sticker laws.

Mr. DAUB. We require disclosure.

Mr. CROMWELL. They cannot charge wealthier people different prices than they charge——

Mr. DAUB. Let me ask the witness if I might, and if my colleagues want to testify, they can in a minute.

I am listening to what you said about the fact that we ought to set prices or mandate what a purveyor takes for their services and that we do the same thing in other parts of our economy.

Mr. CROMWELL. That is not my testimony.

Mr. DAUB. OK. What do you want me to understand from what you are saying?

Mr. CROMWELL. What I am saying is that physicians do balance bill, they do set up differential pricing for the rich and the poor. There is almost nothing that you can do about that. What you can do is get the Government out of the business of condoning and institutionalizing that through case-by-case assignment, allowing them to balance bill.

Mr. DAUB. Do you favor means testing for health care delivery if the Federal Government has anything to do with paying for it?

Mr. CROMWELL. I do not favor means testing in the way it seems to be talked about here in terms of individual patients seeing individual doctors and then letting physicians decide whether or not balance billing should be allowed.

Mr. DAUB. At the schedule of income-related mandatory fees?

Mr. CROMWELL. If you are going to do means testing it would be better to do it at the premium level rather than at the individual physician level. I have also testified that there is a strong economic argument against case-by-case decisionmaking which prevents due to lack of an informed decision, ex ante, particularly before being admitted to a hospital.

Mr. DAUB. So what you are saying is you accuse the doctors of discriminating when they decide who should pay and who should not?

Mr. CROMWELL. Accusation is not the right word.

Mr. DAUB. What is the right word?

Mr. CROMWELL. I think I am stating it more or less as a fact and it has been——

Mr. DAUB. Are you suggesting that that is an improper moral relationship that we are allowing to occur out there in society?

Mr. CROMWELL. Well, it is the law of the land. The economic law of the land is that there should not be that kind of differential billing.

Mr. DAUB. I appreciate your opinion on it.

Now, I was interested in my mother and dad's senior citizens Eastern Area Aging Office newspaper that came out last week. I was home this weekend and I read it. My dad is in his seventies and my mom is just about in her seventies. The newspaper had a column authored by your organization that was very critical of the current effort we are making to expand parts A and B, arguing that our effort is not putting the money where it ought to be.

You were more interested in nursing home and long term care. Are you familiar with that article that your institute published?

Mr. POLLACK. Yes. I authored a piece in the New York Times as well. My comment there was—and it was similar to the testimony I gave before this subcommittee—that the administration's bill is bad, from an equity standpoint it would hurt low-income people. That is why I said, at the beginning of my testimony today, that some of this was significantly corrected by the subcommittee's bill. This is evident particularly in two ways.

One way it was corrected is by the mandatory buy-in for low-income seniors that was adopted apparently unanimously in this subcommittee. I think that is essential, particularly as the premiums are rising. They are going to rise fairly soon even under current law.

Mr. DAUB. And we indexed the programs that cause people to go below the poverty line as well, for other reasons.

Mr. POLLACK. I thought that was a very important contribution and made a very major difference in the bill.

The second thing is, whether one follows the actuarial value approach that was adopted narrowly by the subcommittee, or whether one follows the type of approach that is currently being looked at as an alternative that has a basic premium and a supplemental premium, my hope on that was that as long as we keep the basic

premium low so that we are not exerting too high a burden on low income people to finance this benefit, then I think we are moving in the right direction towards progressive financing.

Mr. DAUB. You do not think we have to make the premium mandatory at a fixed rate cost, like we do on B now for everybody?

Mr. POLLACK. I do not think it should be the same for everybody.

Mr. DAUB. So you favor some kind of an income related approach to these things?

Mr. POLLACK. Absolutely. And I also would want to say that I think that is particularly important in the context of a catastrophic health plan, which is very different than general health insurance. Health insurance generally is first-dollar type coverage. Catastrophic is more in the nature of asset protection.

Mr. DAUB. I agree.

Mr. POLLACK. The example that I used was, let's say, for example, you owned a modest home valued at $30,000, and I owned a mansion worth $3 million. I wanted to protect my asset and you wanted to protect your asset. I think you would be pretty upset if you paid the same premium for that protection as I was paying.

Mr. DAUB. I happen to agree with your approach and I appreciate it. I was trying to get from you, just essentially to the mandatory issue, which I did, and I appreciate your answer.

Mr. Chairman?

Chairman STARK. Thank you. Before I recognize Mr. Levin, I would like to go back to Dr. Cromwell on the discriminatory pricing just to make sure we understand.

It is my understanding that under the Wright-Patman Act, I believe it is against the law to sell a product at one price to one person and at a lower or discriminatory price to another person unless there is a valid business reason like a quantity purchase or something else.

Now, I do not know if that applies to professional fees such as those of lawyers and doctors and dentists. I think what you were referring to is that generally we do not let people sell bedpans at a lower price unless they buy them in volume, or anything else. Was that the referral you were making, that it is against the law in this country to have discriminatory pricing?

Mr. CROMWELL. Yes, that is the basic point, and there are strong economic reasons for not doing that and not squandering the elderly's—pardon?

Mr. DAUB. Would the gentleman yield?

Chairman STARK. Certainly.

Mr. DAUB. Robinson-Patman as a fair trade price and resale maintenance set of laws deals with the conspiratorial aspects of price fixing, and indeed, if someone brings the case, the argument has to be as to whether there is an attempt in violation of one's rights to be affected by price that was not determined only by manufacturing cost or regional concerns or inputs, but if indeed two companies got together to collude. Again, of course, we all understand that.

Chairman STARK. Counsel tells me that is not correct.

Mr. DAUB. Robinson-Patman? Which law?

Mr. BANDEIAN. It is my understanding—I believe it is the Robinson-Patman, it has been a few years since I have been in law

school—but it does prohibit discriminatory pricing, irrespective of any proof of conspiracy.

Mr. DAUB. No.

Chairman STARK. Well, this is obviously beyond the Chair's comprehension.

Mr. DAUB. I tried cases, if you would permit me. Did you ever try a case in court?

Chairman STARK. Guys, we can——

Mr. DAUB. I just want to make my point, again, with the yielding of the chairman, that it is very clear that we have to make a decision in society if we are going to fix price. Now, there is a difference in whether the Government does it or whether we want to interfere if private entities are out there doing it to us. There is a very major difference.

Chairman STARK. Mr. Levin?

Mr. LEVIN. Well, I went to law school before either the staff or Mr. Daub and my recollection of the Robinson-Patman Act is even fuzzier. [Laughter.]

I thought this was going to be the year of more pragmatic and less ideological approaches to medical issues. You might not know it from this morning at times.

I thought that was a solid theme for the year, not so much because ideology is irrelevant, but we can kind of get into ruts with it. So let me just ask several questions of you within that spirit.

First, let me ask Mr. Newsom, because I think Mr. Daub pushed you appropriately for your position on mandatory assignment. What is it besides the fact it is mandatory? Maybe a chronic dislike of things mandatory.

You kind of brag that in Kentucky you have 81 percent participation rate, so I think one way to ask it is, what is the difference between a mandatory system and an 81 percent participation rate? You would brag even more if it were 90, I think.

Mr. NEWSOM. I am not sure we want 90.

Mr. LEVIN. You mean 81 is splendid but 90 is terrible?

Mr. NEWSOM. That would be too many, yes.

Mr. LEVIN. Why is that?

Mr. NEWSOM. Well, there may be just some situations existing where a physician, perhaps, does not want to be a part of that particular program. He may be charging in excess of what we could agree to pay. There are all sorts of reasons why a physician might not wish to be a part of the participation in our program with Blue Shield.

Mr. LEVIN. When you say they want to charge more, that really gets to my question to Ron Pollack. I did not quite understand your response to the chairman about means testing, that it is different for catastrophic coverage than for medical coverage more generally. I mean, there is more involved in Medicare generally than there is in catastrophic, so I did not quite understand the distinction.

Mr. POLLACK. Do you mind if I divert for half a second, and return to your exchange with Mr. Daub about your legal experiences.

Mr. LEVIN. Or lack of it.

Mr. POLLACK. Well, whatever.

Mr. LEVIN. In my case.

Mr. POLLACK. In my previous job I was dean of a law school and I used to have a saying on my wall. It is actually a quotation from Chico Marx, that says——

Mr. LEVIN. Where did he go to law school? [Laughter.]

Mr. POLLACK. He did not go to law school. He said, if you got a problem, get a lawyer. Then you got a bigger problem, but at least you have a lawyer. [Laughter.]

Mr. LEVIN. I am not sure how that cuts, but it sounds like Chico.

Mr. POLLACK. My response in essence was that I think much of what drives the question of means testing is really trying to husband fairly finite resources, normally Government resources, and in effect trying to come up with some equity and better targeting. In the context of husbanding fairly finite resources, I think means testing is a very serious question and it needs to be looked at on a case by case approach.

As I testified before, I think that means testing in certain contexts, like in the catastrophic financing element, makes a great deal of sense.

Now, with respect to mandatory assignment, what I heard the chairman asking before when the previous witnesses were at the table was really a political question more focusing on why not get your foot in the door as opposed to make a decision that had to be all or nothing.

Mr. LEVIN. No. What he was asking was this, why not provide for mandatory assignment except in cases where it is clear people can afford more, to put it in the simplest form?

Chairman STARK. I would say you are both right. If it gets you started, as you mentioned in the Connecticut case, you get 90 percent of the people in the club, that is as good as compromise as I have ever struck.

Mr. LEVIN. But there is a policy basis underlying your question, too. It is not just a foot in the door.

Mr. POLLACK. I guess I was saying I think there is a distinction between means testing when you are trying to ration finite resources and a situation as in mandatory assignment where I do not think that issue is relevant to the rationing of Government resources.

It is not like it is going to cost the Government anything more to have mandatory assignment for everybody than it would be if you did it for 90 or 70 or 50 percent of the people.

Chairman STARK. Could I jump in here a minute if you will yield?

Mr. LEVIN. See, I do not understand that.

Chairman STARK. Well, let me try this. When you income relate a premium, you do not get two tiers. Everybody has got the same insurance then but I am just collecting from you for your Blue Cross or whatever you can afford to pay.

If I means test I have two doors, two classes of people, the bottom half and the other half, or the top, middle and upper third, however we divide it. That could lead you to getting into a two-class system.

Mr. POLLACK. It could affect physician conduct. There is no question that there would be a greater incentive on the part of the physician to provide priority treatment to the higher income people.

Chairman STARK. But if the physician does not know what you are paying me for the insurance, then that physician is——

Mr. LEVIN. Well, that is part of the argument but we do not have the time to go into that. I do not see though that the answer is that there is less money involved because we are dealing with the issue of how we are going to control physician costs, and there we are dealing with a much larger bill than we are with the bill for catastrophic. So I do not see the answer in terms of the impact financially on the system.

We are wrestling with this issue of how to control one of the two or three largest outflows of Federal funds for medical care. Well, we will get back to this in subsequent hearings, but I think it is these underlying policy issues that hopefully will drive our decisions and not just the need to find a billion dollars in a budget resolution, because in the end the policy assumptions drive what we do anyway.

We might as well put them on the table and examine them without labels on them too quickly putting, but we have another witness, so I appreciate this. This has been helpful back and forth.

Chairman STARK. I want to thank the panel particularly. It was very helpful.

One other question, and it is not facetious. Do any of you know of a system, other than a kind of testing the wind system, where physicians are billing according to the ability to pay and have some kind of a system for determining that?

Mr. POLLACK. There are some negotiations among some senior groups with hospitals where those people below a certain income level are being treated on an assigned basis.

Chairman STARK. But nobody has got a form they hand out and sell routinely to a fee-for-service internists office?

Mr. POLLACK. I am unaware of that. These agreements are highly localized. There is nothing statewide. It is not even jurisdiction-wide.

Chairman STARK. Mr. Newsom, do you?

Mr. NEWSOM. Mr. Chairman, that has been done in years past. It did not work too terribly well. I think there is still some of this in Pennsylvania where there is this kind of differential.

We would be glad to look that up for you and see what is going on.

Chairman STARK. I was just curious. I just did not know.

Mr. NEWSOM. We would be glad to look that up, sir.

Mr. DAUB. Mr. Chairman, there are the HMO charges that are differentiated by age, as one of the previous witnesses indicated. They did not do it by dollars, but they did it by where you were on the table.

Chairman STARK. I was thinking of a means evaluation and then some kind of a sliding scale.

Again, I thank the panel very much for their participation today.

Our final witness is Dr. John H. Dawson, American Medical Association, from Seattle, Wash.

STATEMENT OF JOHN H. DAWSON, M.D., TRUSTEE, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY BRUCE BLEHART, DEPARTMENT OF FEDERAL LEGISLATION

Dr. DAWSON. Mr. Chairman, and members of the committee, my name is John H. Dawson, M.D., and I am a physician in the practice of general surgery in Seattle, Wash.

I am also a member of the board of trustees of the American Medical Association. Accompanying me is Bruce Blehart of the AMA's Department of Federal Legislation.

It is a pleasure to have the opportunity to appear before you again. I appeared before this committee 11 months ago, and stated that the participating physician program has been fraught with problems since its inception. Unfortunately, that statement is as true today as it was then. Also, some of the new so-called incentives to become participating passed as part of last year's Reconciliation Act should be reexamined, as they could push the Medicare program toward a two-tiered health care system. Medicare beneficiaries should not be penalized based on the status of their physician.

I would like to inject, that due to the substantial turn of the hearing to the issue of mandatory assignment, I would like to include this additional statement to our prepared and submitted text for the Committee.

Chairman STARK. Without objection.

Dr. DAWSON. The AMA strongly believes that mandated assignment is not necessary and should be opposed.

Going on with our prepared testimony, Mr. Chairman, the AMA recognizes that the intent of the participating physician program is to get more Medicare claims taken on an assigned basis. Encouraging acceptance of assignment is fully consistent with AMA policy and actions urging physicians to consider the needs of their patients in all situations, and to take reduced fees, and, where appropriate, Medicare assignment.

Physicians are heeding the call from the AMA, and Medicare assignment is at an all-time high. Beneficiaries have access in virtually all cases to a physician who will accept assignment. By the end of 1986, 70 percent of all covered charges were accepted on an assigned basis. Based on early data for this year, the figure has jumped to over 71 percent.

The high rate of assignment clearly shows physicians are acting in a responsible manner. We believe that the high rate of assignment is largely due to individual physicians acting upon the financial needs of their patients. While the participating program does have some roll, assignment rates have consistently increased over the lifetime of the program, even while the percentage of participating physicians has remained relatively stable.

However, physicians find that they can face penalties in instances where they do not try to collect deductible and coinsurance amounts. Physicians still await clarification from HCFA on waiving coinsurance and deductible amounts for their needy patients without fear of penalties.

Turning specifically to the participating physician program, multiple problems still persist. It protects those who need no protection. It has caused needless confusion. It is a paperwork nightmare.

It penalizes physicians in a haphazard manner, and it has failed to keep its promises to those who did agree to sign up early in the program.

The AMA recognizes that participation is an individual choice, and we have never told physicians to not participate. Indeed, the AMA was in the forefront of those providing physicians with essential information for their 1987 participation decision.

Even though the AMA diligently worked to provide physicians with adequate information on which to base a 1987 participation decision, the single most important information to consider in making this decision was not available until well after the sign-up period had ended.

Physicians were forced to make a participation decision without knowing the actual impact of the decision, because accurate and complete maximum allowable, actual charge information, MAAC, simply was unavailable. Today, over three months after MAAC information was to have been provided, there are still physicians who have yet to receive complete and/or accurate MAAC information. No citizen, including physicians, should be placed in a situation where the only certain escape from potentially severe penalties is to make a decision to participate, without the essential for that data to be an informed one.

The program has made it possible for program beneficiaries of substantial means to receive medical care services at reduced costs, while the mounting expenses of the medical care practice are passed on to younger patients who may be economically strapped. Such a situation is patently unfair. Furthermore, beneficiaries who seek care from a nonparticipating physician now are penalized as maximum program reimbursement is 4 percent less.

In addition, these patients will be directly penalized by the slow payment rates the adminstration is proposing and the OBRA provision requiring the claims of participating physicians to be paid 7 days after than other claims.

The participating physician program has failed to meet its promises. Operationally, the Government has not fulfilled its promises to those physicians who did decide to become participating.

Delays in promised payment level increases, deliberate payment delays, payment reductions, and fee reductions, have been inflicted on participating physicians. Even physicians who participated right up to January of this year, and decided not to participate for 1987, have had their actual charges capped at a rate unrelated to their recent charge history. Such changes repudiated promises made to these physicians when the participating program was initiated.

In conclusion, Mr. Chairman, we believe that Government activities should be geared to increasing acceptance of assignment in situations where assignment is needed.

This committee must recognize that a major reason why more claims are not accepted under assignment is because the Medicare level of reimbursement does not reflect the real cost of services. If Medicare reimbursement truly reflected the fees in the community, physicians could more readily accommodate those persons with financial needs.

This is just one of the reasons why the AMA is working with Harvard University in the development of a resource-based relative value study.

The AMA will continue to work to accomplish the goal of having physicians accept the Medicare-allowed amount for low-income Medicare beneficiaries.

I will be pleased to answer questions that the subcommittee may have.

[The statement of Dr. Dawson follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

RE: The Medicare Participating Physician Program

Presented by

John H. Dawson, M.D.

May 7, 1987

Dear Mr. Chairman and Members of the Subcommittee:

I am John H. Dawson, M.D., and I am a physician in the practice of general surgery in Seattle, Washington. I am also a member of the Board of Trustees of the American Medical Association. Accompanying me is Bruce Blehart of the AMA's Department of Federal Legislation. The AMA is pleased to accept your invitation to testify today on the Medicare participating physician program.

Mr. Chairman, the American Medical Association recognizes the intent of the participating physician program is to get more Medicare claims taken on an assigned basis. Encouraging acceptance of assignment is fully consistent with AMA policy and actions urging physicians to consider the needs of their patients in all situations and to take reduced fees and, where appropriate, Medicare assignment. However, physicians find that they can face penalties in instances where they do not try and collect deductible and coinsurance amounts. Physicians still await clarification from HCFA on waiving coinsurance and deductible amounts for their needy patients without fear of penalties.

Physicians are heeding this call and Medicare assignment is at an all time high. Beneficiaries have access in virtually all cases to a physician who will accept assignment. Based on the last quarter of 1986, 70% of all covered charges are now accepted on an assigned basis.

The high rate of assignment clearly shows physicians are acting in a responsible manner. While the participating program does have some role, we believe that the high rate of assignment is more a result of individual physicians acting upon the financial the needs of their patients. Assignment rates have consistently increased over the lifetime of the participating physician program even while the percentage of participating physicians has remained relatively stable.

The Participation Program

The participating program should be ended. It seeks to protect those who need no protection. It has caused needless confusion. It is a paperwork nightmare. It penalizes physicians in a haphazard manner. It has failed to keep its promises to those who did agree to sign-up early in the program.

The participating physician program "protects" those beneficiaries who need no protection at the expense of other beneficiaries and other patients. The program has made it possible for program beneficiaries of substantial means to receive medical care services at reduced costs, while the mounting expenses of the medical care practice are passed on to younger patients who may be economically strapped. Such a situation is patently unfair.

The participating physician program has caused needless confusion among beneficiaries and physicians. This program, just by virtue of referring to physicians as either "participating" or "non-participating" implies that physicians are either "good" or "bad" depending upon their participation status. The terminology is needlessly confusing as non-participating physicians do in fact participate in the program and provide care for Medicare beneficiaries. Furthermore, most non-participating physicians accept claims on an assigned basis, and for individual patients assignment may be accepted 100% of the time.

Some Medicare beneficiaries also operate under the mistaken belief that they would be responsible for no part of the physician's bill if services were received from a "participating physician." This fact has caused consternation among participating physicians who found themselves in the position of having to explain the program to those individuals who expected full payment by Medicare.

The participation program is an implementation and administrative nightmare. We have worked to educate physicians on the program. Well before the January 1, 1987 sign-up deadline approached, the AMA had taken a lead role in providing physicians with necessary information to consider in making a participation decision by publishing a detailed question and answer series in AMNews on Medicare and provided answers to questions on the benefits of being a participating physician and the benefits of being a non-participating physician. Although problems in this program persist, the AMA recognizes that participation is an individual choice and we have never told physicians to not participate.

Even though the AMA diligently worked to provide physicians with adequate information on which to base a 1987 participation decision, the single most important information to consider in making this decision was never available until well after the sign up period had ended. Specifically, physicians were forced to make a participation decision without knowing the actual impact of the decision because accurate and complete Maximum Allowable Actual Charge Information (MAAC) simply was unavailable from any source. While physicians were able to make educated guesses on what their MAACs would be, they had to make major economic decisions --with substantial civil penalties attached for noncompliance-- based upon a "best guess." Today, over three months after MAAC information was to have been provided, there are still physicians who have yet to receive complete and/or accurate MAAC information.

The primary incentive given to physicians to participate in 1987 was a stick and not the carrot. No citizen, including physicians, should be placed in a situation where the only certain escape from potentially severe penalties is to make a decision to participate without the essential knowledge for that choice to be an informed one.

The participation program penalizes physicians who choose not to subsidize affluent beneficiaries. Whether called "incentives to participate," "fee freezes," or "MAAC limits," the results are the same. Even the physician who chooses to accept assignment for all cases except for one patient, regardless of how prosperous that patient is, will suffer severe civil penalties. Furthermore, beneficiaries who seek care from a non-participating physician now are penalized, as the maximum program reimbursement is 4% less. In addition, these patients will be directly penalized by the slow payment rates the Administration is proposing and the OBRA provision requiring the claims of participating physicians to be paid seven days faster than other claims. We do not believe that these elements of the participation program belong in a responsible patient care environment.

The participating physician program has failed to meet its promises. Operationally, the government has not fulfilled its promises to those physicians who did decide to become "participating." Delays in promised payment level increases, deliberate payment delays, payment reductions, and fee reductions have been inflicted on participating physicians.

For example, physicians who elected to participate in the first year of the program and decided not to continue in the second year were penalized without warning not only by not receiving a promised increase, but also by having their charges rolled back to the level in effect prior to the program (i.e., the period of April to June, 1984). Even physicians who participated right up to January of this year and decided not to participate for 1987 have had their actual charges capped at a rate unrelated to their recent charge history. Such changes repudiated promises made to these physicians when the participating physician program was initiated.

Participating physicians were subject to further reductions by the penalty incorporated in the Gramm-Rudman-Hollings limitations. That action actually penalized participating physicians and even discouraged others in accepting assignment. From March 1 through September 30, 1986, payment for services provided on an assigned basis was cut by 1%. In other words, physicians who had done the so-called "right thing" by either participating or accepting assignment were penalized for this action. Participating physicians continue to be at risk if Congress again decides to change the rules in the middle of the game.

Conclusion

Rather than target a program to increase assignment for all Medicare beneficiaries regardless of resources, we believe that government activities should be geared to increasing acceptance of assignment in situations where assignment is needed. The AMA is continuing to urge state and local medical societies and other physician groups to adopt programs that encourage physicians to take assignment in all situations where warranted. We are working to increase these activities.

This Committee must recognize that a major reason why more claims are not accepted under assignment is because the Medicare level of reimbursement does not reflect the real costs of services. Medicare reimbursement has been held down through arbitrary controls for well over a decade. If Medicare reimbursement truly reflected the fees in the community, the participating physician program would not only be unnecessary, but physicians could more readily accommodate those persons with financial needs. This is just one of the reasons why the AMA is working with Harvard University in the development of a resource-based relative value study.

The AMA will continue to work to accomplish the goal of having physicians accept the Medicare allowed amount for low-income Medicare beneficiaries. We question, however, whether the participating physician program is an appropriate method toward achieving this goal. We urge you to carefully consider whether the program should be continued into the future.

We will be pleased to answer questions the Subcommittee may have.

ISSUE 3: MANDATORY ASSIGNMENT UNDER MEDICARE... AN UNNECESSARY STEP

Under the current Medicare reimbursement system, a physician may voluntarily assign claims on a case-by-case basis, accepting the Medicare-approved amount as payment in full. Even on assigned claims, the beneficiary is still responsible for paying the applicable coinsurance and deductible. While proposals to mandate assignment are still under consideration by some, the evidence indicates that there is no reason to require that all Medicare claims for physician services be accepted on an assigned basis.

In April of 1984, the House of Representatives rejected a proposal calling for mandated assignment tied to a one-year freeze on the prevailing charge levels for services provided to hospital inpatients. Since that action, Congress created the "participating physician" program, whereby physicians may agree to participate and accept assignment on all claims. The following observations demonstrate why proposals calling for mandated assignment are unnecessary and would be counter-productive.

VOLUNTARY ASSIGNMENT BY PHYSICIANS HAS BEEN EXTENSIVE

Physician acceptance of assignment over the past five years has been extensive. The most recent Medicare data for 1986 indicate that over 68 percent of all Part B claims and 70 percent of charges were accepted on an assigned basis. This continues the trend of increased acceptance of assignment by physicians, as demonstrated by assignment rates of 51 percent in 1980, 53.5 percent in 1983 and 67.7 percent in 1985.

Physicians who take assignment of claims on a case-by-case basis provide the majority of care for Medicare beneficiaries and choose to accept a large percentage of claims on an assigned basis. Almost 61 percent of covered charges for services in 1986 were provided by these physicians, and most took a large number of claims on an assigned basis. Of all claims and charges submitted to Medicare by these physicians, 46 percent were assigned.

With the option of voluntary assignment, and with the high rate of assigned claims, beneficiaries continue to have access to the full range of medical services. Data from AMA surveys of physicians show that the percentage of physicians treating Medicare beneficiaries has increased substantially, from 56 percent in 1982 to 86 percent in 1986, and that the percentage of physicians who accept some claims on an assigned basis has increased from 70 percent in 1982 to 81 percent in 1986.

MANDATORY ASSIGNMENT IS UNNECESSARY

Allowing physicians to take assignment on a case-by-case basis has not resulted in undue hardship for the elderly. Based on 1982 Medicare data when the assignment rate was 52.8 percent, only 1,032,600 of the 25,363,000 aged enrollees, or about 4 percent, had financial liability for their health care in excess of $1,000. In addition, of the over sixteen million Medicare beneficiaries who used physician services, 13,392,600, or 83 percent, had out-of-pocket expenses for Part B services of less than $500. These expenses include both the $75 deductible and coinsurance amounts.

Recent statistics point out that a growing number of elderly are in a position to afford the balance of physicians' regular charges over Medicare payments. Indeed, elderly Americans as a group have the lowest poverty rate and have more discretionary income after taxes and expenses than any other age group in the country.

MANDATORY ASSIGNMENT WOULD BE COUNTER-PRODUCTIVE

There are several reasons why imposing mandatory assignment of claims for physician services would be a disservice to the elderly and the general public. Mandated assignment would shift the financing of the elderly's health care costs to other segments of the population and across generations. Furthermore, requiring physicians to accept assignment for patients who are not in need of such preferential treatment would turn Medicare into a subsidy program for many individuals who are not in need of assistance. Finally, reaching a specific Medicare-eligible age should not automatically result in preferential treatment or automatic entitlement from the government in the absence of financial need.

In sum, mandated assignment would result in subsidizing the cost of health care for a significant portion of elderly who are able to share more of the actual costs of their care.

Rather than increasing the elderly's "financial access" to care, mandatory assignment would reduce the elderly's "actual access" to physician services. A report prepared for Medicare and published in the Summer 1983 Health Care Financing Review demonstrates how access could decline under the "all-or-none" proposal for mandating assignment. The study reports that if physicians were required to decide between accepting all of their Medicare patients on an assigned basis or none of them, only one-third of physicians would choose to accept the assignment option.

VOLUNTARY ASSIGNMENT OF CLAIMS WORKS

The current Medicare reimbursement system, that permits voluntary assignment of claims on a case-by-case basis, gives Medicare patients access to nearly all physicians in the country. This system has not resulted in unwarranted beneficiary liability or excessive balance billing. Physicians continue to consider each patient's financial needs when determining charges and whether to accept Medicare assignment, reduce fees, or charge no fee at all in cases of extreme hardship. The fact that these traditional goals continue to be met is strong evidence that mandated assignment of Medicare claims for physician services is neither necessary nor productive.

Chairman STARK. Thank you, Doctor.

It is interesting that, in your testimony and in the Medicare bulletin you gave us on mandatory assignment, there is no mention of the effect of any of this on the physician's income. Is that correct? Do you recall mentioning this anywhere in your testimony?

Dr. DAWSON. No. I do not.

Chairman STARK. And you do mention, on page 1, you want to consider the needs of the beneficiary. On the same page you talk about where it is appropriate upon the financial needs of their patients. You talk about that again on page 2. And on page 4 you, as a group, choose not to subsidize affluent beneficiaries.

On page 6 you talk about situations where assignment is needed, and on page 6 you talk about all situations where it is warranted.

Then in this bulletin, you talk about undue hardship. You say there is no undue hardship on the elderly. You also talk about the lowest poverty rate, and you talk about service. You say something mandatory would be a disservice to the elderly and the general public.

And then, in your last paragraph, you say that, the system has not resulted in unwarranted beneficiary liability or excessive billing.

I gather that the AMA's sole concern is the same as this committee's, and that is to deal with the financial concerns of the Medicare population. Is that what I am to assume from your testimony?

Dr. DAWSON. No, Mr. Chairman.

Chairman STARK. But you really did not talk about anything else, did you?

Dr. DAWSON. If we could add access, and quality, I think it would be a fairly accurate statement.

Chairman STARK. So I will add that. So you are absolutely indifferent, then, I would assume, as to what a physician makes. That is not the purpose of the AMA. You are just here to deal with access, quality, and service to the elderly and the general public?

Dr. DAWSON. We are not indifferent to the income that a physician makes, because access and quality are, to some extent, linked with that.

Chairman STARK. That is okay. I mean, that is what this committee is pretty generally interested in, and we are interested in how much you make, so we can tax a good portion of that and pay our salaries with it.

So we are coming down the same line. I guess all we have to get to, then, is how we are going to make these decisions. There may be a little "wrassle" as to whether you ought to make that decision, or we ought to.

You practice in private practice as a thoracic surgeon?

Dr. DAWSON. A general and thoracic surgeon with six other partners.

Chairman STARK. Is it fair game for you and me to talk somewhat about your fees and how you set them?

Dr. DAWSON. Indeed, it is.

Chairman STARK. Okay. And you can be general. I do not mean to intrude here on your privacy.

If you take out a gall bladder, in the Seattle area, what is the average charge for a gall bladder removal?

Dr. DAWSON. In dollars, it is between $1,200 and $1,400.

Chairman STARK. Okay. Let's say $1,200 for the sake of my trying to figure out what happens here. What is the Medicare-approved fee?

Dr. DAWSON. I have to plead ignorance on exactly what it is, and I would like to tell you why.

Chairman STARK. All right.

Dr. DAWSON. I have personally chosen not to know which patients have paid their bills, which ones have not, and which ones——

Chairman STARK. I am informed that, let's say it is around $800.

Dr. DAWSON. That is close, I know that.

Chairman STARK. So then, the patient pays $160, and the Government pays $640, Government. Okay. Now what I guess I am saying is, when you say $1,200 to $1,400, how do you decide whether you would charge $800, or $1,200?

Dr. DAWSON. We discuss fees in our office and any patient who requests assignment gets it. Any time that I perceive, on the information sheet that is there, that they may be in that category, I offer it.

Chairman STARK. Okay. Let's get to that a minute. What is on that sheet that they fill out, that would lead you to believe that they were in a category, or in a financial situation where they would be interested in assignment?

Dr. DAWSON. It tells that they are on Medicare, tells whether they are married, and if they are single or a widow. More commonly the older women that I see for gall bladder surgery are widowed, in their seventiess and eighties. I can often tell by their address what area they are from, and I talk with my patients. I find out about their family circumstances in the process of getting the information from them, and find out what their family support system is. We just talk, and in the process I glean information from them which allows me to make that suggestion.

Chairman STARK. And that makes good sense. As a matter of fact, as I recall, and it sounds like what I think of as the small town family physician of the 1920's and 1930's, who knew by osmosis, as I like to say, what went on in the town and who was in need, and who was able to pay, and about how much.

I question whether that goes on in a consistent manner. I have been going to physicians, off and on, since I guess before I was born, and I have never—and in cases where people I guess have no way to suspect one way or the other—had anybody ever ask me. I have always seen a little sign in the waiting room. It does not say I dare you to talk about fees, but it does say we will discuss them.

I have filled out all the forms. You know, you are handed the clipboard with a form asking information generally about insurance and such things. But I have really never had it happen when someone discussed fees.

What I am saying is, that I cannot imagine, from what you said, that we could determine a good system to set some kind of some kind of means test, even though the AMA has said you would accept such a system.

I think, that what you suggested you do would be very hard to write into the law. I get complaints from the AMA now about laws

that are hard to understand. If I wrote it down what you just told us and said, now, you have to do what Doc Dawson does. You have to spend three and a half minutes chatting, and you have to be perceptive. Do you know off the top of your head, at what income level you would only get $800 if you were a participating doctor?

That is $400 less that you are going to get, and that is substantial. Where do you think you ought to make that cut, assuming you only had the two choices?

Could you pick an income figure just for you, I am not trying to hold this as the AMA position.

Dr. DAWSON. Somewhere between two, which is our State's level, two times the poverty level, as established, or three times. I know that my level would be higher, personally, but I would endorse our State medical society's proposal that had been linked with initiative 92, at twice the poverty level.

Chairman STARK. So you are saying that if a person was between $10,000 and $15,000, as a single person, that you would think that assignment would be a fair deal?

Dr. DAWSON. Yes.

Chairman STARK. I believe that in half of the Medicare beneficiaries. We are talking about 15 million people.

Now, I do not think that that many people are getting assignment, and are not getting some form of extra billing. I am just guessing, and we could get the number. But it is a lot of people.

What I am looking for is just you and me to agree. I have to go and vote in a minute.

Mr. Daub.

Mr. DAUB. I will have no questions.

Chairman STARK. You will have no questions. Well, then, we can adjourn, and we can talk about it, if you want to walk over while I vote.

We have agreed pretty much, that there ought to be a system for holding it to $800 for this group of about half of them.

My question is, how do we work that out?

Mr. DAUB. Mr. Chairman, would you yield. Would it make a difference? Would you take into account on your information sheet, whether your patients have a medigap or supplemental policy in force when they check into your office? Would you take that into account?

Dr. DAWSON. I have not. What I would like to see incorporated into the law is some way of making it easier for me to forego the deductibles and coinsurance for those that really need it.

Chairman STARK. Let's talk some more. If you do not mind, I will adjourn the session here, and we can talk some more. We have a vote to make in about 6 minutes, and will be back in about 10 minutes. If you would like to talk about this some more, we would enjoy it.

The subcommittee is adjourned, and the full committee will convene at 3 o'clock for a markup.

[Whereupon, at 1:18 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS

The American Association of Retired Persons, with more than 25 million members, is the largest organization representing Medicare beneficiaries. We welcome the opportunity to submit to the Subcommittee this statement on patient liability under Medicare and the participating physician program.

Growth in Medicare expenditures for physician services rose 18% a year between 1980 and 1984. Indeed, Part B is the fastest growing component of domestic federal programs; annual growth is projected at 14% through 1988. Moreover, this growth comes despite a Congressional freeze on physician fees from July 1, 1984 to December 31, 1986.

AARP believes the current fee for service reimbursement system encourages physicians to set ever higher prices and to deliver more services than may be medically necessary. There is no evidence that patient demand accounts for higher costs. Furthermore, the current payment method exposes beneficiaries to high unpredictable out of pocket costs and disproportionate liability for physician services.

Older Americans depend heavily on Social Security which is indexed to the general inflation rate. Since the cost of physician services and other medical goods and services in general have been rising faster than the CPI, most older Americans have been liable for ever higher out-of-pocket costs for health care. Further Medicare's cost sharing provisions and gaps in coverage lead to heavier out-of-pocket costs for the sickest of the elderly who also are frequently poorer, older and frailer.

Beneficiary Liability for Physician Services

If we look only at physician charges for covered services, we find that beneficiaries are directly liable for 60% of physician charges. This patient liability includes the Part B premium, annual deductible, co-payments for approved charges, and excess billing for unassigned claims. A more complete description is included in the attached fact sheet.

Nearly all beneficiaries pay the Part B premium. Between 1977 and 1986 the Part B premium rose 116%. The 1987 annual premium is set at $214.80 - an increase of 15% over 1986.

The annual Part B deductible of $75 actually represents about $100 in out-of-pocket costs because only allowed charges count toward the deductible and the average reduction on Part B claims is about 26.5%. Beneficiary liability for the 20% Part B co-payment more than doubled between 1980 and 1984. And, despite the participating physician program, charges associated with non-assigned claims totalled $2.6 billion in 1985 - an increase of 100% since 1980.

Even though 71% of Part B claims are now submitted on an assigned basis, there is enormous variation in assignment rates by state, physician speciality, and other factors over which patients have no control. For example, in fiscal year 1986, 93% of Part B claims submitted in Rhode Island were assigned compared with 32% of the claims submitted in Idaho. Wide variations in physician assignment rates have persisted despite program encouragement of physician assignment. In 1985, only one-third of physicians who served Medicare patients signed a participating physician agreement. The fact that a physician accepts assignment does not mean that all such physicians engender the same size bills for similar services. Furthermore, prevailing fee screens vary greatly around the nation for the same procedure by the same specialist.

The publication of directories of participating physicians may do little to insulate patients from high out-of-pocket costs for several reasons: patients have no way of knowing in advance of service the actual amount of their co-payment. Medicare does not reveal to patients the prevailing fee screens or compute for them the difference between each physician's actual charge and the prevailing charge. Therefore, beneficiaries cannot really "shop around" in order to reduce the size of their co-payment.

Participating Physician Program

AARP remains a strong supporter of the participating physician program. We believe mandatory assignment should be part of physician payment reform. The Association continues to support efforts to encourage participation by physicians. This includes bonus payments to carriers who successfully increase th· ıumber of participating physicians in their service area and prompter payment of participating physician claims.

AARP is concerned with the state-by-state effort to mandate assignment. In some states mandatory assignment would not hurt access to physicians. However, there is a real danger in some states, particularly those with low participation or assignment rates, such a step could decrease access to care by Medicare beneficiaries.

AARP encourages Congress to examine reasons why some specialities used by Medicare beneficiaries have lower participation rates than other specialities and to develop targeted efforts to increase participation rates by those specialities.

In addition, AARP applauds Congress for taking difficult steps in the last budget reconciliation legislation to adopt a transition from the fee freeze to a cap on the charges a physician can increase over the Medicare allowed amount to beneficiaries. While this step does not wholly protect beneficiaries, AARP believes that it was necessary to protect the Treasury and the Part B program.

AARP PUBLIC POLICY INSTITUTE ISSUE BRIEF

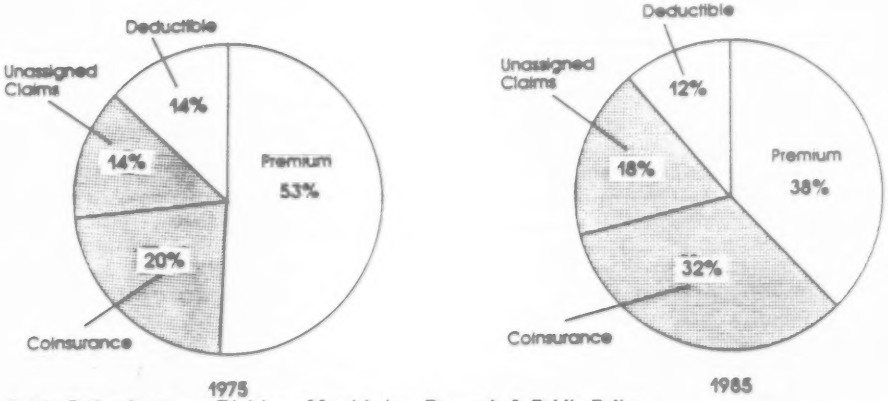
FACT SHEET

MEDICARE BENEFICIARY LIABILITY FOR PHYSICIAN SERVICES

I. Liability for Medicare-Covered Physician Services

Medicare beneficiary liability for physician services consists of four components: Part B premium payments, an annual deductible, coinsurance, and charge reductions on unassigned claims. The relative contribution of these four categories to total beneficiary liability for physician services has shifted over time. In 1975, premium and deductible expenditures represented 67% of total beneficiary liability for physician services. By 1985, coinsurance and charge reductions, two categories of expenditure which are essentially unpredictable, played as significant a role in total physician service liability as premiums and deductibles.

BENEFICIARY LIABILITY FOR MEDICARE-COVERED PHYSICIAN SERVICES

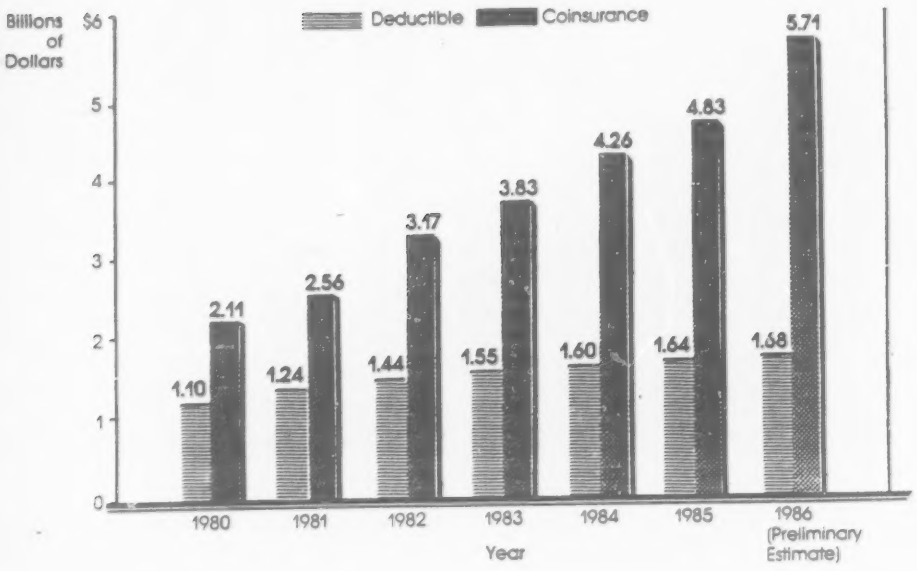


Public Policy Institute • Division of Legislation, Research & Public Policy
American Association of Retired Persons • 1909 K Street, N.W., Washington, DC 20049 • (202) 872-4700

Source: HCFA

Beneficiary payments for the four categories of liability for Medicare-covered physician services have risen steadily. The following charts track increases in liability components since 1980.

MEDICARE PART B DEDUCTIBLE AND COINSURANCE LIABILITY FOR THE AGED*



*Includes Physicians and Other Medical Suppliers

Source: HCFA, Office of the Actuary, January 1987

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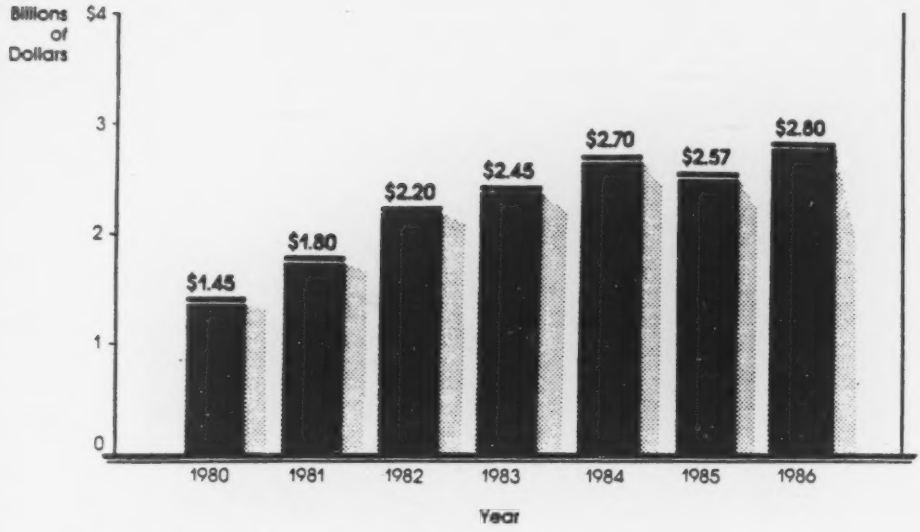
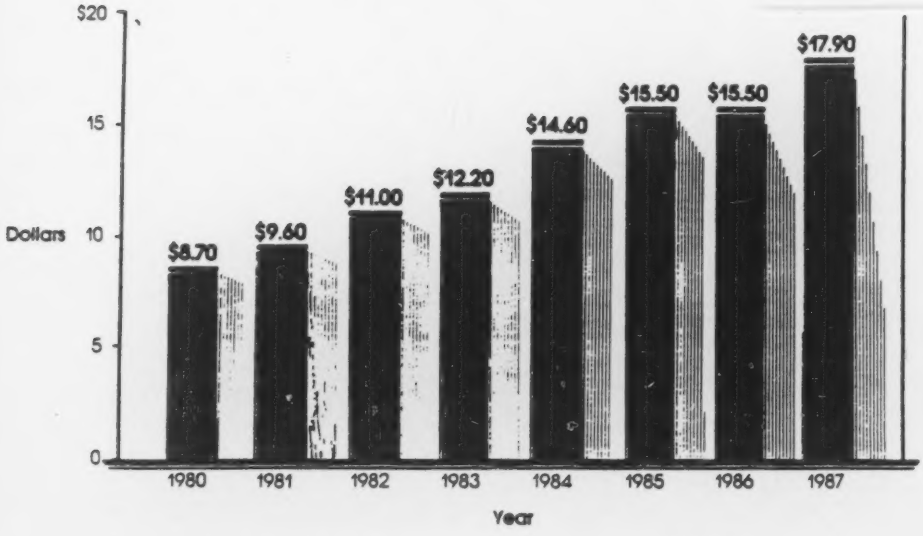
CHARGE REDUCTIONS ON UNASSIGNED MEDICARE PART B CLAIMS*



*Includes Physicians and Other Medical Suppliers
Source: HCFA

MEDICARE PART B MONTHLY PREMIUM

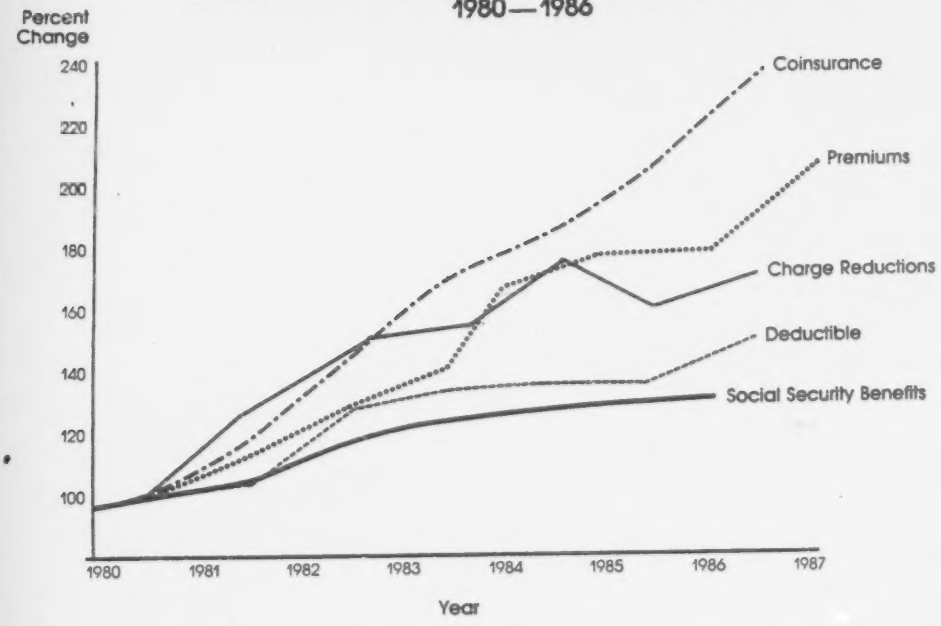


Source: Trustees' Report, April 1986.

While there have been significant increases in all four categories of liability stemming from the use of physician services, there has also been considerable variability in the rate of increase among the four liability components.

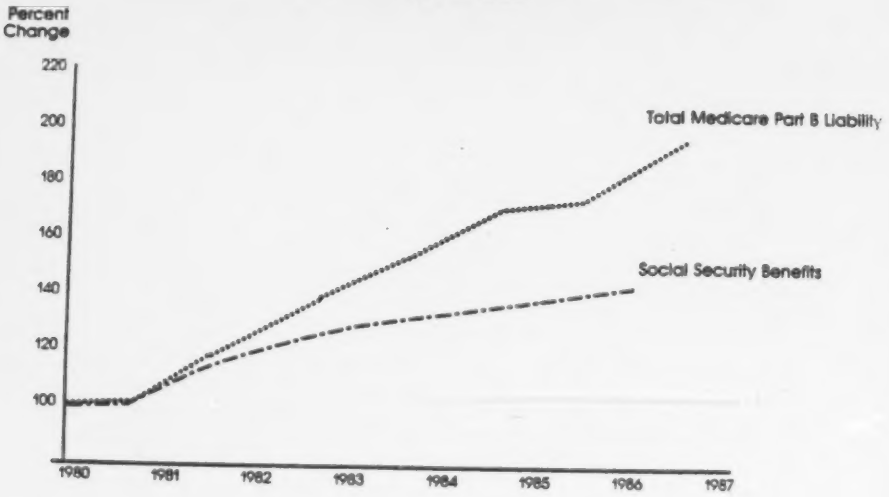
Moreover, increases in Social Security benefits have been unable to keep pace with increases in physician-related beneficiary liability.

COMPARISON OF CUMULATIVE CHANGE IN SOCIAL SECURITY BENEFITS AND COMPONENTS OF MEDICARE PART B LIABILITY 1980—1986



Source: HCFA; Social Security Bulletin

COMPARISON OF CUMULATIVE CHANGE IN SOCIAL SECURITY BENEFITS AND TOTAL MEDICARE PART B LIABILITY 1980—1986



Source: HCFA; *Social Security Bulletin*

II. Who is Affected?

o Part B Premium:	97% of elderly Medicare beneficiaries purchase Medicare Part B coverage.
o Deductible:	80% of elderly Medicare beneficiaries make payments toward the deductible for physician services.
o Coinsurance:	60% of elderly Medicare beneficiaries use Medicare-reimbursed services, thereby triggering coinsurance liability.

- o Charge Reductions on Unassigned Claims: 80% of elderly Medicare beneficiaries with reimbursement for physician services had some liability from unassigned claims in 1982, up from 70% in 1975.

  There is considerable disparity across states in the percent of elderly beneficiaries with unassigned claims, from a low of 51% in Rhode Island to a high of 95% in Oregon. (HCFA is currently unable to provide these figures beyond 1982).

Note: While 80% of elderly Medicare beneficiaries incur liability from the use of physician services, only about 23% incur liability from the use of hospital services.

III. The Impact of Assignment

- o Given the magnitude and unpredictability of beneficiary liability stemming from unassigned claims, the physician's decision to accept or reject Medicare assignment can be critical to the patient.

- o Under Medicare's "participating physician" arrangement, 28.4% of physicians treating Medicare patients in 1986 agreed to accept assignment for all Medicare claims, a drop of two percentage points over 1985. There is, moreover, great disparity from state to state in the percentage of participating physicians from a low of 8% in South Dakota to a high of 54% in Alabama (1986).

  A similar disparity in participation rates exists across specialties, with a low of 22% for anesthesiologists to a high of 46% for nephrologists.

- o The 1985 assignment rate was 68.5%, up dramatically from the 1984 rate of 59%. This improvement in assignment rates is attributable in large part to the implementation of the participating physician program in 1984. Moreover, gains seen in assignment rates in 1985 seem to have held in 1986, when assigned claims made up 68% of the total.

  (It should be noted that the current assignment rate for non-participating physicians is about 44%).

Medicare Part B Assignment Rates
1968-86

Year	Percent of Claims Assigned
1968	59.0
1970	60.8
1972	54.9
1974	51.9
1976	50.5
1978	50.6
1980	51.5
1982	53.0
1984	59.0
1985	68.5
1986	68.0

Source: HCFA

- Still, there remains significant variability in assignment rates across states. In 1986, 92% of claims submitted in Massachusetts were assigned, while only 35% were assigned in South Dakota. Assignment rates for specialties vary, as well, but HCFA has not updated these since 1982.

- Most physician charges submitted to Medicare are reduced prior to reimbursement. Between 1971 and 1985, the percent reduction on physician charges increased from 11.4% to 26.9%. The beneficiary bears the full financial burden of such reductions on all unassigned claims.

- The recent increase in unassigned claim liability during a period characterized by high assignment rates suggests possible increases in volume, the use of more expensive physician services, the influence of the two percentage-point decline in the physician "participation" rate, or a combination of these three.

IV. The Role of Medigap

- Most Medicare supplemental (Medigap) policies marketed since the enactment of the Baucus Amendment in 1980 are required to cover Medicare Part B coinsurance subject to a maximum plan deductible of $200 per year; they must also carry a maximum Part B benefit of not less than $5000. Relatively few Medigap plans cover even a portion of unassigned claim liability, and the cost of such coverage is usually prohibitive.

- o About 70% of elderly Medicare beneficiaries purchase Medigap insurance plans. About 90% of these individuals are covered for inpatient physician care, and about 62% are covered for physician office visits.

- o The cost of Medigap insurance ranges from about $200 to $1,200 per year, depending on the breadth and depth of coverage.

V. Elderly Out-of-Pocket Expenditures for Physician Services

Elderly out-of-pocket expenditures for physician services (including payments for non-Medicare covered services) are large and rising. Between 1977 and 1984, such expenditures increased by 195%.

	1977	1984	Percent Increase
	Billions		
Out-of-Pocket:	$2.2	$6.5	195%
Private Insurance:	$1.2	$3.4	183%

Revised February, 1987.

STATEMENT

OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

TO THE

HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

ON

MEDICARE PARTICIPATING PHYSICIAN PROGRAM

MAY 15, 1987

Introduction

The American Society of Internal Medicine (ASIM), representing internists nationwide who specialize in internal medicine, appreciates the opportunity to share with Congress its views on Medicare's participating physician program, the individual assignment option and mandatory assignment.

ASIM is strongly committed to protecting beneficiaries from excessive out-of-pocket expenses for physician services, by providing appropriate incentives for physicians to discount fees or to accept assignment on services provided to low income beneficiaries. Indeed the Society has a long record of support for voluntary measures to constrain the cost of physician services, including being the first medical organization in 1983 to endorse a temporary freeze on physician fees, and more recently, initiating a major nationwide effort to address the special needs of low income Medicare beneficiaries. ASIM has also pledged to work with the American Association of Retired Persons (AARP), the Physician Payment Review Commission (PhysPRC), Congress, and other appropriate groups to identify additional incentives for physicians to accept assignment or to discount fees for services provided to low income beneficiaries. Several possible incentives to improve acceptance of Medicare's "approved charge" for services provided to patients in need are discussed later in this statement.

ASIM, however, remains strongly opposed to unnecessary and intrusive governmental programs, such as the participating physician program or proposals to mandate Medicare assignment across the board, that are at best unnecessary and ineffective, and at worst may do great harm to the quality and availability of medical care provided to patients enrolled in Medicare. While ASIM recognizes that many of those who favor such measures may be well intentioned, the Society believes that a careful analysis of the facts demonstrate that the current individual assignment option best serves the needs of Medicare patients without the risks inherent in more regulatory approaches.

Medicare's Current Individual Assignment Option

Medicare's individual assignment permits physicians to decide--on a claim-by-claim basis--whether or not to accept Medicare's "approved amount" as "payment in full"--or, alternatively, to "balance bill" the patient for the difference between Medicare's allowable charge and the physician actual charge. If the physician accepts assignment, the physician sends his or her bill directly to Medicare, which in turn sends a reimbursement check to the physician. If the physician chooses not to accept assignment, he or she bills the patients directly and the patient collects the allowable reimbursement from the Medicare program.

Critics of Medicare's individual assignment option argue that it hurts Medicare beneficiaries by making them vulnerable to high out-of-pocket expenses in those cases where the physician chooses not to accept assignment. The facts show, however, that the vast majority of Medicare patients are well served by the current individual assignment option.

Statistics show that the physician acceptance for assignment has increased over the last several years. According to the Health Care Financing Administration (HCFA), in 1979 over 50 percent of all claims were assigned and over 50 percent of the total charges by physicians were on assigned basis. In 1982, acceptance for assignment had increased to 52.8 percent of all claims and 54.2 percent of total charges. More recently, acceptance

for assignment has increased even more dramatically. By 1985, 67.8 percent of all Medicare claims and 67.4 percent of all charges were accepted on an assigned basis. In 1986, assignment was even higher, with 68.6 percent of all claims and 69.5 percent of all charges accepted on an assigned basis. HCFA Administrator William R. Roper, MD, recently testified that in 1987, acceptance of assignment has increased to 71 percent of total charges.

Moreover, statistics show that physicians typically accept assignment for older, sicker, and poorer patients. In 1986, beneficiaries paid an average of $93.00 (excluding co-payments and deductibles) for physician charges above the Medicare approved amount, an increase of only $37.00 since 1980. Although beneficiaries' out-of-pocket expenses for Part B services are considerably higher, those costs are largely attributable to increases in federally required co-payments and deductibles. In 1980, beneficiaries paid an average of $137.00 in co-payments and deductibles. By 1986, however, that amount had nearly doubled to $265.00.

Further, data collected by HCFA in 1979 revealed that physicians are much more likely to accept assignment on claims submitted by patients who incur large medical bills. For example, while physicians in 1979 usually did not accept assignment for patients who incurred annual charges of less than $100.00, they accepted assignment in the majority of cases where patients had incurred total annual charges of $2,500 or more. Similarly, in 1979 physicians accepted assignment on 44.4 percent of the total charges of beneficiaries between the ages of 65 and 69; for beneficiaries over 85 years physicians accepted assignment for about 60 percent of the total charges. Although ASIM is not aware of more recent studies that compare beneficiaries' costs or ages by physician acceptance assignment, the fact that overall assignment rates have substantially increased since 1979 makes it reasonable to conclude that physicians in 1987 are accepting assignment to an even greater extent for those beneficiaries who have high medical bills, are in financial need, or are older.

All these numbers, taken together, strongly support the conclusion that the individual assignment option, in general, protects those patients who are most in need: older, poorer and sicker Medicare beneficiaries with high medical care expenses. Therefore, proposals to mandate assignment--either on a nationwide or state by state basis--or to coerce physicians into becoming "participating" physicians (a form of de facto mandatory assignment) are examples of legislative overkill. Instead of attempting to mandate assignment across the board, Congress would be well advised to work with the medical profession to identify those relatively few instances where Medicare patients in need may, through lack of information or inappropriate incentives, not be adequately protected from excessive out-of-pocket expenses, and then to develop appropriate, targeted approaches that will assure that those patients are adequately protected in the future.

In developing such targeted approaches, it may be helpful for Congress to understand some of the reasons why many physicians continue to exercise their option to accept assignment on a claim-by-claim basis, and how they take their patients financial circumstances into account in exercising that option in a responsible manner.

Individual Physicians and the Individual Assignment Option

The vast majority of physicians today continue to exercise their right to accept assignment on a claim-by-claim basis, as evidenced by the fact that only slightly over one-third of all physicians have signed up to become "participating" physicians, despite the increasing propensity for Congress to impose punitive measures on non-participating physicians. There are many important reasons why individual physicians may decline to accept assignment on all claims. Many physicians, for example, have a mix of relatively affluent Medicare patients and those with more limited means. The Individual claim-by-claim assignment option allows physicians to accept assignment on those in need while charging their usual fee to those who can afford to pay it. For those physicians, maintaining the flexibility to do so is a critical factor in the decision not to become "participating" physicians. Although some have questioned whether or not physicians are able and qualified to determine whether or not their patients' financial circumstances necessitate acceptance of assignment, ASIM strongly believes that a patient's personal physician is best situated to make this determination, by virtue of his or her long standing relationship with that patient. Certainly, it is far better for this highly personal decision to be made by the doctor and the patient than by some outside governmental "agency" that would arbitrarily determine whether or not an individual should be eligible for assignment according to some predetermined criteria for special assistance.

Other physicians are unwilling to accept assignment on all claims because of concern that this removes the patient from the equation, thereby weakening the doctor-patient relationship and undermining the quality of medical care available to their patients. Still others do not participate simply because they cannot afford to accept Medicare payment levels for all services as "full payment."

For all these reasons, the vast majority of physicians--given the freedom to do so--will continue to exercise their rights to accept assignment on individual claim-by-claim basis, unless federal and state governments impose a public policy of forcing physicians into accepting Medicare assignment on all claims. A national policy designed to coerce physicians into accepting assignment, either by legally mandating acceptance of assignment or imposing increasingly punitive measures on those physicians who decline to become "participating", will seriously undermine the quality and availability of medical care provided to patients.

The Participating Physician Program

During the past several years, Congress has devoted most of its efforts towards creating incentives for physicians to sign up as "participating" physicians (e.g. by providing higher reimbursement for services provided by participating physicians), and by imposing punitive measures on non-participating physicians (such as limits on their actual charges and delays in reimbursement update). The operating assumption appears to be that the best way to protect beneficiaries from liability for higher out of pocket expenses is to direct them toward "participating" physicians. ASIM strongly believes, however, that this strategy is fundamentally flawed.

Given the fact that only one third of all physicians have signed up to become participating, it is clear that much of the recent increase in assignment rates is due to the efforts of non-participating physicians to accept assignment on an increasing proportion of their Medicare patients. Since most Medicare beneficiaries receive care from non-participating physicians--and are likely to do so for the foreseeable future--it seems reasonable that efforts should be made to encourage increased acceptance of assignment on a claim-by-claim basis by non-participating physicians, rather than simply attempting to expand the pool of participating physicians. Although in time more physicians may sign up to become "participating" if sufficient incentives are provided, ASIM believes that for the foreseeable future most physicians--given the choice--will continue to exercise their option to accept or not accept assignment on the individual claim basis. Therefore, public policy based solely and simply on expanding the participating physician program is likely to fail, since it will not be responsive to the needs of the vast majority of patients who will continue to exercise their right to receive care from non-participating physicians. Therefore, as discussed later in this statement, ASIM strongly believes that Congress should explore new incentives to increase acceptance of Medicare's "approved amount" by those physicians who continue to exercise the individual claim-by-claim assignment option, with such incentives targeted toward those low income patients who actually need such protection, rather than devoting its efforts to expanding the pool of participating physicians.

Mandatory Assignment

An alternative strategy advocated by some would force physicians into accepting assignment--either by legally mandating it on a state or national level or by imposing increasingly punitive measures on those who decline to participate. Mandatory assignment carries with it the grave potential of severely weakening the patient-physician relationship and undermining the quality and availability of care provided to Medicare beneficiaries.

Under mandated assignment, the physician is placed in the position of working for the government, not the patient. Mandated assignment allows the government to determine not only the level of payment for a given service but also in what circumstances patients can freely contract with their physicians to obtain needed medical care. Under mandated assignment, patients will not have the freedom to contribute to the cost of a service (except for required co-insurance and deductibles), since any payment above Medicare's "approved amount" could result in sanctions against the physician. As a result, if Medicare's "approved amount" is insufficient to cover the cost of providing necessary services, the physician and his or her patient no longer will have the ability to arrange for the patient to continue to receive that service at a fair and reasonable fee. As the government continues to reduce payments for Part B services for budgetary

reasons, physicians and patients will increasingly be constrained in their freedom to choose the nature of the care provided to the patient. In short, under mandated assignment it is the government that will determine what services are available to patients--determinations that all too often will be made based on budgetary constraints rather than what is in the best interests of the individual Medicare patient.

Similarly, mandatory assignment is likely to hurt beneficiaries' access to medical care. Although the medical profession is and will remain committed to providing their patients enrolled in Medicare with the best quality of care possible, regardless of whatever punitive measures are imposed by the government, it is likely that a point will eventually be reached where Medicare's payment levels simply are not sufficient to cover the costs of providing quality medical care to patients. When that occurs, physicians will be put in the position of making adjustments in their practices that, over the long run, will not be in the interests of Medicare patients--not because they do not want to provide the highest care possible, but because Medicare's payment policies will make it impossible for them to do so.

Already, there is evidence that Medicare's payment levels for some services are insufficient to cover the costs of providing those services. Last year, ASIM conducted a random survey of internist-members nationwide on Medicare payment policies. Although the survey admittedly was not conducted in an entirely scientific manner, the results nonetheless were startling: Medicare's "approved amount" for a routine return office visit in many parts of the country currently is at, or only nominally above, the actual overhead costs incurred in providing that service. Therefore, physicians who accept assignment on those routine office visits receive virtually no compensation from Medicare for the time spent with the patient, since virtually all of Medicare's approved charge for the service goes directly to paying overhead expenses. This finding, although disturbing, is not entirely surprising, given the fact that Medicare traditionally has undervalued certain primary care, cognitive services--a conclusion that has been borne out repeatedly in major studies of Medicare payment policies. It is in recognition of this historical undervaluation of cognitive services that Congress mandated that HCFA developed a relative value scale (RVS) based on resource cost factors, such as time complexity, training, and overhead cost. A resource cost RVS, by assigning relatively more weight to time consuming, complex cognitive services, could begin to correct this historical undervaluation. But whether or not the results of that study will actually be used by policymakers to improve payment for those undervalued services remains to be seen.

Certainly, Congress' track record on Medicare physician payment over the past several years leaves the medical profession and patients with little or no confidence that payment levels will be set at a fair and reasonable level in the future. As a result of the Medicare fee freeze, Medicare payment levels for non-participating physicians in 1987 are only 3.2 percent higher than what physicians were charging in 1983--a four year gap between Medicare payment levels and physician charges. During that period of time, inflation and physician overhead costs have increased at a far greater pace. Therefore, primary care physicians in particular have absorbed the dual blow of the historical undervaluation of their primary care services coupled with a freeze on payment levels at a time when their costs have risen steadily. It is largely because of Medicare's low payments for such services that internists and other primary care physicians often will accept assignment on inpatient services but not on office visits, except for those patients in particular financial need.

ASIM has no doubt that a significant improvement in payment levels for undervalued primary care services will substantially increase overall assignment rates. In fact, a 1984 study found that by improving payment levels for medical services, Medicare could significantly increase assignment rates for all services, including ancillary services. (Rice. "Determinants of Physician Assignment Rates by type of Service" in Health Care Financing Review, Summer, 1984). Those who are attempting to mandate assignment, however, are asking primary care physicians to accept as full payment current levels of reimbursement for their services that often do not meet the costs of providing those services. Moreover, even if future payment levels are later based on a resource cost relative value scale, ASIM has no confidence that Medicare payment levels, even if initially adequate, would keep pace over time with the costs providing those services. Congress' long history of cutting Medicare expenditures to achieve budgetary savings suggests strongly that once physicians and patients are locked into mandatory assignment, payment levels will be permitted to lag until a point is reached where they will no longer cover the costs of providing necessary services.

Once that point is reached--as it already has been for certain services--physicians would be faced with some difficult choices. Since under mandatory assignment they no longer would be permitted to work out an arrangement with the patient so that the patient contributes some amount above Medicare's "approved amount", physicians would have little choice but to deal with inadequate levels of reimbursement by spending less time with Medicare patients, no longer accepting new Medicare patients, no longer seeing any Medicare patients, or ultimately, moving to a two-tiered system, where private patients receive a higher level of care than their Medicare counterparts. No physician wants this to occur. But ASIM strongly believes that this will be the inevitable result of any proposal to mandate assignment or to force physicians to sign up as "participating" physicians. Therefore, the Society strongly urges Congress to reject both mandatory assignment and punitive measures designed to coerce physicians into participating, in favor of positive incentives to improve the predictability of Medicare assignment for low income beneficiaries.

Positive Approaches to Protecting Low Income Beneficiaries From High Out-of-Pocket Expenses

What then can be done to protect low income beneficiaries from high out-of-pocket expenses for their medical care?

ASIM strongly believes that much can, and is being done, to address the special needs of this group of Medicare beneficiaries. As noted previously, physicians are accepting Medicare assignment on an increasing number of claims, with poorer patients and those with large medical care expenses being the primary beneficiaries of this trend. ASIM recognizes, however, that a small minority of Medicare patients in need may at times be liable for out-of-pocket expenses for physician services that are in excess of what they can afford. As a starting point to address this problem, ASIM recommends the following positive approaches.

1. Medicare patients should have the right to know what their physician charges for a given service, how much Medicare will pay toward that service, and whether or not Medicare assignment will be accepted. This should be done in advance of rendering services, whenever necessary. ASIM has already gone on record as urging all physicians to discuss their fees and assignment policies with their Medicare patients. Moreover, if and when Medicare moves towards a predictable schedule of allowances based on resource costs--as strongly favored by ASIM--Medicare patients will have the information needed to select physicians whose charges are at or only nominally above Medicare's "approved amounts".

2. Congress should recognize the important role played by the growing number of voluntary programs initiated by national, state and county medical societies, senior groups, and others to assure that all low income Medicare patients are protected from excessive out-of-pocket expenses. ASIM recently launched a nationwide program titled "Personal Care" that is one example of this type of program. Under the "Personal Care" program, enrolled physicians agreed to inform their patients in of their willingness to :

   - o discuss fee, assignment, and billing arrangements in advance of rendering services whenever possible.
   - o to assist any Medicare patient in filing unassigned claims.
   - o to accept Medicare's "approved amount" for any patient in financial need. Patients needing such special arrangements are provided with wallet cards or letters of understanding that guarantee that they will be charged no more than Medicare "approved amount" for services provided by that physician.

- to request that other physicians involved in treating those patients in financial need also accept assignment or discount their fees to Medicare's approved amount.

This program addresses perhaps the biggest problem with the individual assignment option: The fact that at times patients may not know that their physician is willing to accept Medicare's "approved amount" if they are in financial need or that they may feel reluctant or embarrassed to ask their physician do so. Moreover, it does this in a way that provides ongoing assurance to the patient that for an agreed upon period of time, the physician will always accept assignment or discount his or her fees. Therefore, it minimizes the lack of understanding and communication that, in a small minority cases, may result in some needy patients not receiving special financial protection from their personal physician.

3. Congress should mandate improved payment for undervalued primary care, cognitive services as one step to improving overall assignment rates. Several studies demonstrate that overall assignment rates will increase if payment levels are adequate and appropriate for historically undervalued primary care services.

4. Congress, senior citizen groups and the medical profession should work together--not against each other--to identify other reasonable, targeted approaches for assuring that patients in need are protected from excessive out-of-pocket medical care expenses. The approaches described in this statement suggest that much is already being done to address this compelling need. But far more can be accomplished, ASIM believes, if the medical profession, Congress, and senior citizen groups begin to work together to identify positive approaches to help those who truly need assistance, rather than fighting a divisive, unnecessary, and counterproductive battle over mandatory assignment.

Conclusion

ASIM appreciates the opportunity to share its views with Congress. The Society pledges to work with Congress, senior citizen groups and others in developing positive, workable, and appropriate measures to improve protection for low income beneficiaries from higher out-of-pocket medical care expenses. ASIM remains strongly opposed, however, to mandatory Medicare assignment and punitive programs designed to coerce physicians into signing up as "participating" physicians as unnecessary, counterproductive and harmful approaches that, all too often, have stood in the way of working together towards the common goal of protecting all low income patients from financial harm.

G-BD-0761a/ksk

TESTIMONY OF ERIC KRISS, PRESIDENT
MEDIVISION, INC.
BEFORE THE HEALTH SUBCOMMITTEE
HOUSE WAYS AND MEANS COMMITTEE
THURSDAY, MAY 7, 1987

Mr. Chairman, Members of the Subcommittee, I sincerely appreciate the opportunity to submit testimony to you today on physician participation under the Medicare program. As the chief executive officer of the leading provider of outpatient eye surgery in the United States, MediVision, Inc., I am intimately concerned with delivering the highest quality health care to Medicare beneficiaries at the lowest possible cost and to improving physician participation in the program.

MediVision represents a direct outgrowth of the government-sponsored movement towards outpatient settings for surgery, and specifically towards ambulatory surgical centers. Our patients, who are treated at seventeen Medicare-certified ambulatory surgical centers in eleven states, all benefit from a skilled network of optometrists and ophthalmologists who perform a full range of eye care services.

As a for-profit corporation, MediVision's existence is dependent upon producing a modest profit while providing high quality care at the lowest possible costs to the government. In my testimony today, I would like to recommend specific proposals that will improve physician participation under Medicare while continuing to promote low-cost outpatient surgery settings.

I am confident I can speak from real experience about containing health costs. Conservatively speaking, from 1984 to 1986 alone, MediVision facilities saved American taxpayers as much as $20 million in performing low cost cataract/implant surgeries for Medicare beneficiaries, assuming these patients would have otherwise been treated at more expensive hospital outpatient departments. Through our services today, MediVision physicians diagnose and treat approximately three percent of all

U.S. eye disease, largely for our elderly citizens, many suffering from cataracts. By reaching and helping an underserved, low-income Medicare population, I estimate our facilities currently save Medicare over $2 million per month versus the same treatment in hospital outpatient departments.

As you can see, the inception of ambulatory surgical centers has spurred greater cost-efficiency as well as competition in the medical marketplace. Likewise, it has fostered new ways of developing cost-saving partnerships between physicians and facilities that are important to both the Medicare program and the patients we serve.

Before I discuss this partnership and suggest several areas of potential reform, I would like to briefly cite the legislative background and the issues that have arisen by virtue of changes enacted in last year's omnibus budget bill that affect providers of outpatient surgery.

Last year's budget reconciliation legislation (PL 99-509) contained several provisions which altered the way facility providers of outpatient surgery, including hospital outpatient departments and freestanding ambulatory surgical centers, are treated under Part B of Medicare. The significant issues raised by the reconciliation legislation included these concerns:

1) The Secretary's non-compliance with Congressional intent to periodically review and update facility fees paid to ambulatory surgical centers;

2) The cost-based methodology of calculating payments made to hospitals for surgical procedures performed in hospital outpatient departments, which apparently results in unjustifiably high program expenditures;

3) Whether continued waiver of the Part B copayment requirement, through which ambulatory surgical centers have historically received 100 percent Medicare fee reimbursement for facility services, (an incentive for patients to utilize low-cost ambulatory surgical centers for outpatient surgery), is appropriate given

the maturity of the ambulatory surgical center industry.

Each of these concerns was addressed through the following three provisions:

1) The Secretary shall establish a new fee schedule for ambulatory surgical centers no later than June 30, 1987, subject to review and update annually thereafter;

2) The Secretary shall develop and implement a prospective payment schedule for hospital outpatient departments effective for cost-reporting periods beginning October 1, 1989, and for all periods thereafter. In the interim, the Secretary shall make payments to hospitals for procedures performed in hospital outpatient departments based on the following formulae:

a) for the cost-reporting period beginning October 1, 1987, a blend of 75 percent hospital outpatient department costs and 25 percent of the applicable ambulatory surgical center rate, and;

b) for the cost-reporting period beginning October 1, 1988, a blend of 50 percent hospital outpatient department costs and 50 percent of the applicable ambulatory surgical center rate;

3) that ambulatory surgical centers shall be subject to the Part B beneficiary copayment requirement.

Overall, these measures succeed in moving hospital outpatient departments and ambulatory surgical centers toward a more "level playing field" for outpatient surgery. We clearly foresee, however, and the evidence increasingly shows, that the combination of continued high payments to hospital outpatient departments along with the termination of the copayment waiver

for ambulatory surgical centers will produce the unintended effect of patient choice of high-cost hospital outpatient departments over low-cost ambulatory surgical centers. In many areas where ambulatory surgical centers have been developed, competing hospital outpatient departments routinely waive Part B copayment amounts in apparent violation of federal law (see references to routine waiver raised by the Subcommittee on Health and Long-Term Care of the House Select Commmittee on Aging in "Cataract Surgery: Fraud, Waste, and Abuse," July 19, 1985).

The intent of Congress in establishing beneficiary copayments was to give Medicare beneficiaries a financial incentive to become active rather than passive consumers of health care. The Part B copayment requirement, however, was waived at the inception of the Medicare ambulatory surgical center program in an effort to encourage patients to utilize these low-cost facilities.

Hospital outpatient departments have always been subject to the copayment requirement for facility costs. For hospital outpatient departments, routine waiver of copayments -- failing to attempt to collect copayment amounts from beneficiaries regardless of the beneficiaries' ability to pay -- flies in the face of Congressional intent. Yet in virtually every area served by an ambulatory surgical center there is at least one hospital outpatient department that routinely waives beneficiary copayments in an effort to gain a competitive advantage in attracting Medicare beneficiaries. Advertisements touting "free surgery" and "no cost for Medicare recipients," once commonplace, have in large part been replaced by word-of-mouth among patients and practitioners, or the front office staff's winking of an eye at an elderly person's inquiry about out-of-pocket costs.

This situation exists for two reasons. First, hospital outpatient department reimbursement is high enough to allow profit despite routine waiver (and will likely remain sufficiently high until prospective payment for hospital outpatient departments is implemented October 1, 1989); and

second, the Department of Justice has expended no effort towards the enforcement of copayment collections law -- hospital administrators consequently have virtually no fear of being prosecuted for their transgressions.

Routine waiver by hospital outpatient departments becomes particularly critical as ambulatory surgical centers lose 100 percent Medicare reimbursement. This is so because payments to ambulatory surgical centers are so low, and the profit margins so thin, ambulatory surgical centers are not able to survive financially if they routinely waive copayment. In fact, the only times when ambulatory surgical centers will waive copayment will be for patients clearly demonstrating indigence, as intended by Congress for hospital outpatient departments and ambulatory surgical centers. As ambulatory surgical centers begin to collect copayment amounts and Medicare beneficiaries learn of routine copayment waiver practices by hospital outpatient departments, the choice becomes academic: utilize an ambulatory surgical center and pay $200 or more, or a hospital outpatient department and pay nothing.

Of course, facility services costs are only one component of the total costs of outpatient surgery performed on Medicare beneficiaries. The most significant cost of any surgical procedure performed either in a hospital outpatient department or an ambulatory surgical center is the physician's surgical fee. Under Part B of the program, physicians are given the option on an annual basis of "participating" in Medicare. Through participation in the Medicare program, a physician agrees to accept Medicare assignment as payment in full for all services performed on beneficiaries, and so foregoes the right to "balance bill" beneficiaries for amounts beyond the allowable coinsurance and deductible amounts as determined by Part B carriers.

Physician participation in the program is especially desirable because it provides a means of Medicare control over total physician costs as paid both by the program and by beneficiaries. Yet nationwide only three in ten physicians

participate in Medicare today. One strong explanation for this is the method used to calculate allowable charges under the program which actually discourages new physician participation over time.

Under the reasonable charge methodology of calculating allowable physician charges, a hierarchy has been established that discriminates against new providers and encourages physicians to develop historical "profiles" of charges at levels as high as possible. New physicians' allowable charges are limited to rates substantially lower than those of physicians that have established sufficiently high charges over time. As a result, many younger physicians have little choice but to decline to accept assignment and to discriminate against poorer elderly patients.

For new physicians, balance-billing is the only way to make up the difference between what Medicare allows them and the prevailing rate allowed established physicians. Clearly, the reasonable charge system provides a disincentive for new physicians, as well as those physicians that have failed to play the reasonable charge game by charging as much as possible, to participate in the Medicare program.

This lack of participation means many elderly patients are subject to fee surcharges of 25% or more which must be paid out-of-pocket. Low-cost ambulatory surgical centers currently have no incentive to convert their physicians to Medicare participation since facility and professional services fees are separately administered under Part B of the Medicare program.

To address this issue and suggest an appropriate remedy in part, we respectfully submit for Congressional consideration the following minor changes in Part B that, if adopted, would result in significant savings to elderly Medicare beneficiaries and to the program trust fund:

1) If a Medicare certified ambulatory surgical

center agrees to restrict surgical privileges to participating physicians, all of that center's fees (including facility fees and prosthetic devices) for Medicare-approved ambulatory surgical center procedures shall be 100% paid by Medicare and the beneficiary coinsurance requirement shall be waived;

2) participating physicians on the medical staff of an ambulatory surgical center qualifying for 100% facility reimbursement under 1) above are guaranteed maximum "area prevailing" reimbursement for all fees, regardless of individual "actual and customary" charge profiles.

The most prudent timing of the effective date of these provisions is from enactment through such time as the Secretary implements a prospective payment system for hospital outpatient departments.

The collective benefits of enacting these reforms include:

1) Providing a financial incentive for elderly Medicare beneficiaries to use the lowest cost facilities by eliminating out-of-pocket expenses for services performed at ambulatory surgical centers;

2) Ensuring that designated ambulatory surgical centers and their participating physicians are the absolute lowest cost providers of surgery;

3) Establishing complete Medicare control over applicable physician fees while providing substantial incentive for physician participation, and;

4) Eliminating physician surcharges over Medicare-approved reimbursement rates for procedures performed at designated ambulatory surgical centers.

Another area identified this session by Congress as exhibiting substantial room for reduction in Medicare program costs are physician fees paid for radiology, anesthesiology and

pathology, which as a group has been dubbed RAP. The concern that led to the RAP proposal is that fees paid to radiologists, anesthesiologists, and pathologists for services provided in conjunction with inpatient hospital stays are increasingly uncontrollable and should be capped. The proposal would bundle physician fees for RAP services into hospitals' normal diagnosis related group (DRG) payments for inpatient facility services. In this manner, hospitals would receive direct payments for all services including RAP, and would negotiate its own arrangements with RAP physicians. The great benefit of the RAP proposal is that it both reduces RAP costs and establishes absolute predictability of those costs.

Physician fees for RAP services provided through hospital outpatient departments and ambulatory surgical centers, however, remain uncapped. Outpatient surgery therefore represents a loophole through which RAP physicians will continue to charge high fees, taking whatever Medicare pays and balance-billing beneficiaries.

We propose that ambulatory surgical centers and hospital outpatient departments, like inpatient hospitals under the original RAP proposal, be paid prospectively determined fees for providing RAP services associated with approved ambulatory surgical center procedures. The benefits of adopting prospective RAP payments to ambulatory surgical centers and hospital outpatient departments include:

1) eliminating excessive surcharges by RAP physicians for outpatient surgery;

2) controlling RAP costs for outpatient surgery, just as the RAP DRG policy will contain inpatient costs.

Providing for 100 percent reimbursement of fees for facility services and prosthetic devices when an ambulatory surgical center's medical staff fully participates in the Medicare program, offering physicians the incentive to participate by ensuring that all participating physicians qualify for maximum

allowable charges, and paying ambulatory surgical centers and hospital outpatient departments prospectively determined rates for RAP services:

1) will guarantee that designated ambulatory surgical centers and their participating physicians shall combine to provide outpatient surgery at the lowest possible cost to the program;

2) will provide considerable incentive for Medicare beneficiaries to utilize these designated lowest-cost ambulatory surgical centers;

3) will significantly encourage physician participation in the program;

4) will cap costs of RAP services provided in conjunction with outpatient surgery;

5) will reduce total costs of outpatient surgery, including fees for facility services, physicians' fees for surgery, and fees for other coincident medical services, and;

6) will move the program substantially closer to complete predictability of the total costs of outpatient surgery.

Finally, we would like to briefly share with you some information concerning the performance of the Secretary with respect to the legislative requirement that fee levels for facility services provided by ambulatory surgical centers under the Medicare program (which have not been modified since originally set in 1982):

1) be updated no later than July 1, 1987;

2) be reasonably related to costs incurred by ambulatory surgical centers in providing outpatient surgical facility services.

The Secretary is experiencing great difficulty in attempting to comply with these requirements. Through the Health Care Financing Administration, the Secretary has gathered ambulatory surgical center cost data through a mid-1986 survey. The survey data has yet to be analyzed, and industry sources have discerned that the Secretary has proposed as an interim measure, for review by the Executive Office of Management and Budget, to increase ambulatory surgical center fees for facility services by a percentage equivalent to the aggregate increase in the overall Consumer Price Index for all urban consumers (CPI-U) as compiled by the Bureau of Labor Statistics. In theory, the Health Care Financing Administration's analysis of cost survey data will be completed in time for July 1, 1988 review and modification of fee schedule for ambulatory surgical center facility services.

We concede that the time needed to fully analyze ambulatory surgical center cost survey data precludes the data's meaningful use to update fees for ambulatory surgical center facility services by July 1, 1987. We take exception, however, to the Secretary's selection of the overall CPI-U as the fee inflator, which is tantamount to claiming that the increase in retail VCR prices, for example, from 1982 (when ambulatory surgical center facility fees were first introduced) through 1987 is a reasonable approximation of the increase in the costs of providing outpatient surgery.

The Bureau of Labor Statistics compiles the general CPI-U by tracking consumer costs over time of many different kinds of goods and services. The Bureau in fact tracks several categories which offer a fine discernment of changes over time in consumer costs of a myriad of medical goods and services. We suggest that the Secretary reconsider the use of the general CPI-U in favor of the CPI-U medical services component, which obviously offers a more accurate gauge of changes over time in the costs of delivering medical care.

Thank you very much for your consideration.

STATEMENT OF

FORMER CONGRESSMAN JAMES ROOSEVELT

CHAIRMAN OF THE

NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. Chairman, I am James Roosevelt, chairman of the National Committee to Preserve Social Security and Medicare, and I represent over four million Americans, most of whom are Medicare beneficiaries who frequently are forced to pay extra charges on non-assigned claims for doctor fees. We recognize your efforts as a champion of Medicare beneficiaries to protect beneficiaries from the $3 billion financial burden of these extra charges. While the Medicare "participating doctor" program has helped many beneficiaries to find doctors who accept assignment, only mandatory assignment can really protect seniors from this financial burden. We urge you to lead a campaign for mandatory assignment and pledge ourselves to work with you to pass such a law.

National Committee members frequently express dismay and anger in letters to me about uncontrollable out-of-pocket costs for doctor fees when their doctor does not accept assignment. They don't understand why Medicare pays only 50 percent of their doctor bills when they were told that Medicare would pay for 80 percent. They usually cannot get their private medigap insurance, if they have it, to pay for extra charges, which average over $33 a claim. And it is frequently up to beneficiaries rather than the doctor to fight for appropriate reimbursement when the seriousness of their condition justifies a larger than average payment.

In some cases, Medicare's approved charge may be unreasonably low. But in many cases, we believe that non-participating doctors are overcharging to pad their annual incomes, which average over $100,000, with an extra $7,500 a year at the expense of senior citizens. In either case, Medicare beneficiaries are caught in the middle.

The participating doctor program, enacted in 1984, has helped beneficiaries find doctors who always accept the Medicare-approved charge as full payment, thus limiting their out-of-pocket costs to 20 percent of the approved amount. But almost 75 percent of doctors have refused to join the participating doctor's program. And while overall assignment rates increased in 1985, both assignment rates and the number of participating doctors have begun to drop.

The participating doctor program does not solve the problem of extra charges. As a general rule, seniors are reluctant to disrupt long-standing relationships with their doctors even if they don't accept assignment. In some areas of the country, only a few doctors are participating doctors. In rural areas, many seniors have little choice of doctors.

For example, in 1986, physician participation rates ranged from eight percent in South Dakota to 54 percent in Alabama. Or, comparing just states known as retirement centers, the participation rate was 15.4 percent in Arizona, 25.7 percent in Florida and 30 percent in California. Put another way, even if he or she has time to shop around, a senior citizen in California has a less than a one-in-three chance of locating a physician who won't charge in excess of the Medicare-determined reasonable fee. But that's double the chances of the senior citizen living in Arizona!

Even the most careful medical care shopper can be caught up short by the present system. As one of our members reported, he and his wife sought out a participating doctor and were fortunate to locate a reputable doctor in whom they had confidence. Nevertheless, when the wife was hospitalized, the additional specialists called in to care for her were not participating doctors and did not accept assignment. "She was too sick to even lift up her head," the husband wrote. "I couldn't be there full time. Was she supposed to ask everyone who came in the room if they would accept the Medicare payment? And what could we have done even if we had known they would refuse?"

As a consequence, the National Committee urges Congress to pass H. R. 1923 introduced by Congressman Brian Donnelly and make assignment mandatory for doctors who treat Medicare patients. With Medicare reimbursement averaging 18 percent of doctors' incomes and with increased competition among doctors for patients, most doctors cannot afford to lose Medicare patients. To assure senior citizens access to quality medical care in all cases, the National Committee will also be urging states to pass licensing laws, similar to one in Massachusetts, requiring doctors to accept assignment from Medicare beneficiaries.

Many doctors refuse to accept assignment because they claim that Medicare-approved charges are not fair. We certainly agree that the current payment system distorts the market for doctors' services because it encourages doctors to raise their fees, to choose specialty practices rather than primary care practices and to practice in higher income urban areas rather than rural or low-income areas. Across the board freezes also tend to punish doctors who have kept their fees reasonable all along and do nothing to roll back exorbitant fees of other doctors.

Whether Medicare-approved fees are fair or unfair, we believe no better system will be designed and implemented until doctors are required to accept assignment from Medicare for every claim. As long as doctors have the option of refusing direct payment from Medicare and billing patients for more than the Medicare-approved charge, they have little or no incentive to negotiate for a more equitable payment system. If the current system is faulty, the National Committee believes it is the responsibility of doctors to work with Congress and the Administration for payment reform.

If the interests of Medicare beneficiaries are to come ahead of the interests of the medical profession, the first thing Congress should do is make assignment mandatory rather than try to encourage doctors to join the participating doctor program.

Thank you.

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